DENVER HEALTH MEDICAL PLAN, INC.

SIGNATURE SHEET
(Groups with 51+ Lives)

The attached Member Handbook for both the Denver Medical Care HMO plan, and Denver Medical Care DHMO plan, and ("**Exhibit 1**"), including any amendments thereto, which constitutes the applicable Evidence of Coverage, including the Schedule of Benefits and Copayment Schedules therein, all applicable Riders, all applications by the Subscribing Group and Subscribers, this Signature Sheet and any Amendments thereto, and the attached Performance Guarantees ("**Exhibit 2**"), collectively constitute the HMO Contract ("**HMO Contract**") between Denver Health Medical Plan, Inc. ("**DHMP**"), and the Subscribing Group named below for the provision of health care benefits to eligible persons electing to enroll hereunder as Members.

1. **SUBSCRIBING GROUP.**

(a) The name, address and group number of the Subscribing Group are as follows:

City and County of Denver ("**City**")
Office of Human Resources
201 West Colfax Ave., Dept. 412
Denver, CO 80202

Group numbers: CSA Plan A, 99994444 and MCRCSAP (Medicare primary due to ESRD/disability)

(b) The following entities which are affiliated with the Subscribing Group shall be deemed to be included within the Subscribing Group for the purposes of the HMO Contract: N/A

2. **EFFECTIVE DATE AND TERM.** The HMO Contract shall be effective as of 12:01 a.m., Denver time on January 1, 2013, ("**Effective Date**") and shall remain in effect until 11:59 p.m., Denver time on December 31, 2013, subject to the terms and conditions set forth in the HMO Contract.

3. **COVERAGE.**

(a) Plan Type: Denver Medical Care and Denver Medical Care Deductible

(b) Evidence Of Coverage Edition Date: January 1, 2013.

(c) Copayment Schedule Edition Date: January 1, 2013.

(d) Optional Benefits: See the attached DHMP Member Handbook(s).

4. **MONTHLY PREMIUMS.**

The undersigned Subscribing Group shall pay the monthly premiums to DHMP, as indicated on the attached Monthly Premium Schedule, which Monthly Premium Schedule is included at **Attachment A** and is made part of this HMO Contract.

The monthly processing dates:

On the first (1^{st}) Premiums due for current month. Grace period for premiums due begins. Standard grace period is thirty-one (31) days. On the tenth (10^{th}) day following the premium due date, coverage will lapse and claims are suspended. 30^{th}. Lapse notice sent if premium payment has not been received by DHMP.

Cancellation notice will be mailed at least four (4) business days following the end of the grace period. Premium payment is due within ten (10) days of the date of the cancellation notice or policy will be cancelled.

Coverage may be reinstated after notice of cancellation has been sent by making payment within ten (10) days of the date of the cancellation notice.

Payments should be sent to: Denver Health Medical Plan, Inc.
777 Bannock Street, MC 6000
Denver, Colorado 80204
Attn: Manager of Finance

The Subscribing Group shall notify DHMP of enrollments, terminations or other changes within ninety (90) days. DHMP will not accept retroactive additions or terminations after ninety (90) days. No adjustment in premium(s) or coverage shall be granted by DHMP to the Subscribing Group for more than ninety (90) days of coverage prior to the date DHMP was notified of the change.

In the event of a conflict between the terms of the enrollment form and the terms of the applicable Member Handbook, the terms of the applicable Member Handbook shall prevail.

5. **ELIGIBILITY.**

The following conditions of enrollment and eligibility shall be applicable to Subscribing Group in addition to the conditions specified in the attached Member Handbook(s). To the extent that any of the following conditions contradict those stated in the attached Member Handbook(s), the following shall prevail:

Eligibility Rules: Required regular work each week for Subscribing Group: 20 hours per week or greater, unless the Eligible Employee is a retired member of DERP.

New hire waiting period: Employees and dependents are eligible on the first day of the month which follows the employee's initial date of employment.

6. **UNDERWRITING CONDITIONS.** The Subscribing Group agrees that the underwriting conditions listed below exist as of the effective date in Paragraph 2 above, and agrees that all such underwriting conditions shall continue to be met at all times while the HMO Contract is in effect.

(a) Employer has the right to determine the percentage of premium it will pay on behalf of its employees. Employer agrees to inform DHMP of its percentage of premium contribution at or near the time of enrollment for underwriting purposes.

(b) Non-emergency healthcare services obtained by Eligible Employees and dependents outside of the DHMP service area or from a provider who is not a participating provider in the DHMP network may not be covered. To help ensure proper coverage, Eligible Employees and dependents should obtain all of their non-emergency healthcare services within the DHMP approved service area, and from a DHMP participating provider, unless otherwise agreed to or approved by DHMP. Eligible Employees should refer to the applicable Member Handbook for additional information and requirements.

(c) All Eligible and participating Employees must be scheduled to regular work, a minimum of twenty (20) hours, unless otherwise stated in Paragraph 5 above.

7. **OPEN ENROLLMENT PROVISIONS.** The Group Open Enrollment Period shall end at least thirty (30) days prior to the new enrollment period with all required enrollment documentation received by DHMP Marketing.

All information should be sent to:

Denver Health Medical Plan, Inc.
Attn: Member Services
777 Bannock St. MC 6000
Denver, Colorado 80204-4507

Subscribers must either complete and sign an approved enrollment application or enroll through the City's online enrollment process in order to be eligible for enrollment with DHMP.

Subscribing Group shall provide DHMP with an electronic member enrollment report on a weekly basis to permit DHMP to verify member enrollment data.

8. **TERMINATION.** The HMO Contract may be terminated by the Subscribing Group on the anniversary of the Effective Date, upon thirty (30) days' advance written notice to DHMP or the first to occur of the following:

(a) At any time by order of the Colorado Commissioner of Insurance;

(b) By DHMP, at any time, ten (10) days after the date of the cancellation notice pursuant to Paragraph 4. Coverage will continue through the end of the period for which premiums have been paid;

(c) By DHMP, upon thirty (30) days' advance written notice, if any underwriting condition listed in Paragraph 6 is not being met;

(d) By DHMP, at any time, upon thirty (30) days' advance written notice, due to fraud or intentional misrepresentation of material fact on the part of Subscribing Group with respect to health benefit plan coverage;

(e) By DHMP, upon the occurrence of any terminating event, and with such advance notices, as provided in Section 10-16-201.5 C.R.S., and applicable regulations, as the same may be amended from time to time, or successor statute or regulations of similar tenor and effect; or

(f) By DHMP, should it discontinue to offer its large group health plans in accordance with C.R.S. §10-16-201.5(6).

Subscribing Group may renew coverage subject to underwriting conditions, the eligibility requirements, and the other terms and conditions of DHMP in effect at the time of renewal. Renewal is also subject to DHMP's right to discontinue offering its large group health plan and to the other terms and conditions contained or referenced herein.

9. **INSURANCE:**

(a) General Conditions: DHMP agrees to secure, at or before the time of execution of this Agreement, the following insurance covering all operations, goods or services provided pursuant to this Agreement. Contractor shall keep the required insurance coverage in force at all times during the term of the Agreement, or any extension thereof, during any warranty period, and for three (3) years after termination of the Agreement. The required insurance shall be underwritten by an insurer licensed or authorized to do business in Colorado and rated by A.M. Best Company as "A-"VIII or better. Each policy shall contain a valid provision or endorsement requiring notification to the City in the event any of the required policies be canceled or non-renewed before the expiration date thereof. Such written notice shall be sent to the parties identified in the Notices section of this Agreement. Such notice shall reference the City contract number listed on the signature page of this Agreement. Said notice shall be sent thirty (30) days prior to such cancellation or non-renewal unless due to non-payment of premiums for which notice shall be sent ten (10) days prior. If such written notice is unavailable from the insurer, contractor shall provide written notice of cancellation, non-renewal and any reduction in coverage to the parties identified in the Notices section by certified mail, return receipt requested within three (3) business days of such notice by its insurer(s) and referencing the City's contract number. If any policy is in excess of a deductible or self-insured retention, the City must be notified by the Contractor. Contractor shall be responsible for the payment of any deductible or self-insured retention. The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Contractor. The Contractor shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

(b) Proof of Insurance: DHMP shall provide a copy of this Agreement to its insurance agent or broker. DHMP may not commence services or work relating to the

Agreement prior to placement of coverages required under this Agreement. DHMP certifies that the certificate of insurance attached as **Exhibit 3**, preferably an ACORD certificate, complies with all insurance requirements of this Agreement. The City requests that the City's contract number be referenced on the Certificate. The City's acceptance of a certificate of insurance or other proof of insurance that does not comply with all insurance requirements set forth in this Agreement shall not act as a waiver of DHMP's breach of this Agreement or of any of the City's rights or remedies under this Agreement. The City's Risk Management Office may require additional proof of insurance, including but not limited to policies and endorsements.

(c) Additional Insureds: For Commercial General Liability DHMP shall name the City and County of Denver, its elected and appointed officials, employees and volunteers as additional insured.

(d) Commercial General Liability: DHMP shall maintain Commercial General Liability insurance coverage with limits of $1,000,000 for each occurrence, $1,000,000 for each personal and advertising injury claim, $2,000,000 products and completed operations aggregate, and $2,000,000 policy aggregate.

(e) Business Automobile Liability: DHMP shall maintain Business Automobile Liability coverage with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this Agreement

(f) Managed Care Liability: DHMP shall maintain limits of $1,000,000 per claim and $1,000,000 policy aggregate limit.

(g) Technology Errors & Omissions including Cyber Liability: DHMP shall maintain Technology Errors and Omissions insurance coverage including cyber liability, network security, and privacy liability coverage with limits of $1,000,000 per occurrence and $1,000,000 policy aggregate.

10. **DISPUTE RESOLUTION PROCESS**. Neither the Group nor DHMP may initiate litigation to resolve any dispute without first attempting to resolve the dispute with the other party. The Parties agree to meet in a good faith and collaborative effort to resolve the dispute, pursuant to the process specified in Article 4.10 of the Amended and Restated Operating Agreement between the City and County of Denver and Denver Health and Hospital Authority

11. **GOVERNING LAW AND VENUE; DAMAGES LIMITATION.** The HMO Contract shall be governed and construed in accordance with laws of the State of Colorado. Any action or legal proceeding commenced or maintained by Subscribing Group or any employee or DHMP Member relating to or arising out of this HMO Contract or health plan must be exclusively venued in a court of competent jurisdiction located in the City and County of Denver, Colorado. Subscribing Group, for itself and on behalf of its employees and their dependents who are covered individuals under this HMO Contract, agrees and consents to such venue and the subject matter and personal jurisdiction of such court located within Denver, Colorado. No court is empowered to award punitive damages or damages in excess of compensatory damages.

12. **AMENDMENT.** This Signature Sheet may be amended by mutual consent of DHMP and the Subscribing Group, unless such amendment is required by a change in law, in which case such amendment shall be made upon ninety (90) days advance written notice to the Subscribing Group. Further, this Signature Sheet may be amended solely by DHMP at renewal pursuant to C.R.S. 10-16-214(3)(a)(IV) if all large groups covered by the same DHMP health plan are uniformly modified.

13. **INDEMNIFICATION.** DHMP shall, to the extent permitted by Colorado law, defend and indemnify the City with respect to any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred solely as a result of any of the following: DHMP's breach of this Agreement, from breach of any fiduciary responsibility that DHMP may have under applicable law, or as a result of other negligent act of DHMP which was the sole cause of the claim. This obligation to defend or indemnify does not extend to claims or causes of action against DHMP or City based in whole or in part on the acts, representations, or omissions of the City or other third party.

DHMP's obligation to defend and indemnify shall apply only to lawsuits in which both the City and DHMP are named defendants. In discharging its obligation to defend as set forth above, DHMP's counsel shall represent the interests of both DHMP and the City. With respect to any such lawsuit, DHMP shall keep the City informed of all significant developments and shall receive and consider any legal advice offered by the City. The City shall provide DHMP with reasonable notice of any actual or threatened action which may be indemnifiable pursuant to this Section.

Neither DHMP nor DHHA waives any rights under the Colorado Governmental Immunity Act or any other provision of Colorado State law.

14. **AGENCY.** The City is not DHMP's agent or representative, and the City shall not be liable for any acts or omissions of DHMP's officers, agents or employees.

15. **APPROPRIATION.** Notwithstanding any other term or condition or covenant of this Agreement, it is understood and agreed that any payment obligation of the City hereunder, whether direct or contingent, shall extend only to funds appropriated by the Denver City Council for the purpose of this agreement in the year in which the obligation is incurred, encumbered for the purpose of this agreement and paid into the Treasury of the City. DHMP acknowledges that (i) the City does not by this Agreement irrevocably pledge present cash reserves for payments in future fiscal years, and (ii) this agreement is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

16. **MAXIMUM CONTRACT AMOUNT**. The maximum contract amount for the City's obligation under this Agreement during the Term of January 1, 2013 through and including December 31, 2013, shall not exceed FOUR MILLION FIVE HUNDRED THOUSAND Dollars ($4,500,000.00), without amendment of this Agreement.

17. **PROHIBITION AGAINST EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT**:

This Agreement is subject to Article 17.5 of Title 8, Colorado Revised Statutes, and as amended hereafter (the "**Certification Statute**") and DHMP is liable for any violations as provided in the Certification Statute.

DHMP certifies that, at the time of the execution of the Agreement, DHMP does not knowingly employ or contract with an illegal alien and that it has, through its parent organization DHHA, confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement through participation in either the federal E-Verify program (see www.uscis.gov and www.uscis.gov/files/nativedocuments/E4_english.pdf) or the State of Colorado Department of Labor and Employment Program (the "**Department Program**") (see http://www.colorado.gov/dpa/dfp/sco/contracts/Unauthorized_Immigrants.htm), as defined in § 8-17.5-101(1).

DHMP shall also comply with the following provisions:

(1) It shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(2) It shall not enter into a contract with a sub-consultant or subcontractor that fails to certify to DHMP that the sub-consultant shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(3) It has confirmed the employment of all employees who are newly hired for employment in the United States through participation in the E-Verify program or the State of Colorado Department of Labor and Employment Program.

(4) It is prohibited from using the E-Verify Program or the State of Colorado Department of Labor and Employment Program to undertake pre-employment screening of job applicants while performing its obligations under the Agreement.

(5) If it obtains actual knowledge that a sub-consultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal alien, it will notify such sub-consultant or subcontractor and the City within three days. DHMP will also then terminate such sub-consultant or subcontractor if within three days after such notice the sub-consultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three day period the sub-consultant or subcontractor provides information to establish that the sub-consultant or subcontractor has not knowingly employed or contracted with an illegal alien.

(6) It will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S.".

18. **CONFIDENTIAL INFORMATION.** DHMP shall not at any time or in any manner, either directly or indirectly, divulge, disclose or communicate to any person, firm or corporation in any manner whatsoever any City information which is not subject to public disclosure, including without limitation the Health Insurance Portability and

Accountability Act of 1996 and the regulations thereunder as amended ("**HIPAA**"), the trade secrets of businesses or entities doing business with the City, the data contained in any of the data bases of the City, and other privileged or confidential information. This provision shall not prevent DHMP from using information as needed for the normal operation of a health maintenance organization, including but not limited to, quality assurance reviews, utilization management, claims processing, and any reporting or auditing required by the Colorado Division of Insurance or any other governmental agencies having jurisdiction over DHMP. This obligation shall survive the termination of this Agreement. DHMP shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. Further DHMP shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is given.

19. **NO DISCRIMINATION IN EMPLOYMENT.** In connection with the performance of work under this Agreement, DHMP agrees not to refuse to hire, discharge, promote or demote, or to discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, marital status, or physical or mental disability; and further agrees to insert the foregoing provision in all subcontracts hereunder.

20. **COLORADO GOVERNMENTAL IMMUNITY ACT.** The parties hereto understand and agree that both are relying upon, and have not waived, the monetary limitations (presently $150,000 per person, $600,000 per occurrence) and all other rights, immunities and protection provided by the Colorado Governmental Immunity Act, C.R.S. §24-10-101 *et seq*.

21. **AUDIT.** DHMP agrees that it will keep and preserve for at least six (6) years all directly pertinent books, documents, papers and records of DHMP involving transactions related to this Agreement, and that it will give the City's authorized representatives access during reasonable hours to examine and/or copy such books and records, subject to applicable state and federal confidentiality laws.

22. **VALIDITY.** The unenforceability or invalidity of any part of this Agreement shall not affect the enforceability and validity of the other terms and conditions of this Agreement.

23. **CITY EXECUTION OF AGREEMENT.** This Agreement is expressly subject to, and shall not be or become effective or binding on the City until it is approved by Denver City Council and fully executed by all signatories of the City and County of Denver.

24. **COUNTERPARTS.** This Signature Sheet may be executed in two or more counterparts, each of which shall constitute an original but all of which shall constitute one and the same document.

Contract Control Number:

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of

SEAL

CITY AND COUNTY OF DENVER

ATTEST:

By_____

_____

APPROVED AS TO FORM:

REGISTERED AND COUNTERSIGNED:

By_____

By_____

By_____

Contract Control Number: CSAHR-201310658-00

Contractor Name: Denver Health Medical Plan

By: _____

Name: LeAnn Donovan
(please print)

Title: Chief Executive Officer
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

ATTACHMENT A

MONTHLY PREMIUM SCHEDULE

2013 HMO rates

Denver Health Medical Plan, Inc. Rates for Calendar Year 2013 Approved by the Colorado Division of Insurance	
Employee	$515.73
Employee & Spouse	$1,074.91
Employee & Child(ren)	$833.57
Employee and Family	$1,490.46

2013 Deductible HMO rates

Denver Health Medical Plan, Inc. Rates for Calendar Year 2013 Approved by the Colorado Division of Insurance	
Employee	$438.22
Employee & Spouse	$913.37
Employee & Child(ren)	$708.31
Employee and Family	$1,266.48

EXHIBIT 1
To Denver Health Medical Plan, Inc. Service Agreement

MEMBERSHIP HANDBOOK(S)

Member Handbook

WE TAKE YOUR
HEALTH
personally.

Career Services Authority (CSA)
and DERP Non-Medicare Primary
Denver Medical Care
HMO

2013

1 Schedule of Benefits

Denver Health Medical Plan, Inc.
Career Service Authority and DERP Non Medicare
Denver Medical Care HMO - 2013 Summary of Benefits

	In Network	Out-of- Network
1. DEDUCTIBLE TYPE	None	None
2. DEDUCTIBLE **a) [Individual] [Single]** **b) [Family] [Non-single]**	a) Not applicable b) Not applicable	Not applicable
3. OUT-OF-POCKET ANNUAL MAXIMUM **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) No out-of-pocket maximum b) No out-of-pocket maximum c) Not applicable	Not covered
4. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	Not applicable
5. COVERED PROVIDERS	Denver Health and Hospital Authority providers, Columbine Chiropractic, and Denver Health Medical Center. See provider directory for a complete list of current providers.	Not covered
6. WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 5 ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes.	Not applicable
7. MEDICAL OFFICE VISITS/ SERVICES **a) Primary Care Providers** **b) Specialists**	a) $25 copay b) $40 copay	Not covered
8. PREVENTIVE CARE **a) Children** **b) Adults**	a) $0 copay per visit for well-child exams b) $0 copay per visit for annual preventive care exams. $0 copay per visit for well-woman exams	Not covered
SCREENINGS • **Colonoscopy** • **Mammogram** • **All preventive screenings rated A or B by USPSTF**	$0 copay	Not covered

	In Network	Out-of-Network
9. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care**	a) $25 copay per visit b) $300 copay per admission	Not covered
10. PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions**	If prescription filled at a Denver Health Pharmacy (30-day supply): Discount: $4 copay Tier 1: $10 copay Tier 2: $15 copay for brand name drugs Tier 3: $30 copay for non-preferred drugs Denver Health Pharmacies or Pharmacy Delivery by Mail (90-day supply): Discount: $8 copay Tier 1: $20 copay Tier 2: $30 copay for brand name drugs Tier 3: $60 copay for non-preferred drugs If prescription filled at a non-Denver Health Pharmacy (30-day supply): Discount: $8 copay Tier 1: $20 copay Tier 2: $30 copay for brand name drugs Tier 3: $60 copay for non-preferred drugs (PA) If prescription filled at a non-Denver Health Pharmacy (90-day supply): Discount: $16 copay Tier 1: $40 copay Tier 2: $60 copay for brand name drugs Tier 3: $120 copay for non-preferred drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
11. INPATIENT HOSPITAL	$500 copay per admission Pre-authorization required	Not covered
12. OUTPATIENT/ AMBULATORY SURGERY	$200 copay Pre-authorization required	Not covered

1 Schedule of Benefits

	In Network	Out-of-Network
13. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI and PET scans**	 a) 100% covered b) $200 copay	Not covered
14. OTHER DIAGNOSTIC AND THERAPEUTIC SERVICES **a) Sleep study** **b) Radiation therapy** **c) Infusion therapy (includes chemotherapy)** **d) Injections** **e) Renal dialysis**	 a) $400 copay per visit b) $10 copay per visit c) $10 copay per visit d) $20 copay per visit (immunizations, allergy shots and any other injection given by a nurse is a $0 copay) e) Covered at 100%	Not covered
15. EMERGENCY CARE	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)
16. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
17. AMBULANCE	$450 copay per trip (not waived if admitted)	$450 copay per trip (not waived if admitted)
18. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$50 copay per visit	$50 copay per visit
19. BIOLOGICALLY-BASED MENTAL ILLNESS AND MENTAL DISORDERS	a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit	Not covered
20. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	 a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit Virtual Residency Therapy is considered outpatient care and the outpatient copay applies for each day of service	Not covered
21. ALCOHOL & SUBSTANCE ABUSE **(If not covered under #19 above as a mental disorder)**	a) Detoxification: $500 copay per admission. Pre-authorization required. b) Inpatient: $500 copay per admission. Pre-authorization required. c) Outpatient: $40 copay per visit	Not covered
22. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$50 copay per visit. Maximum benefit is 20 visits per calendar year per type of therapy.	Not covered

	In Network	Out-of-Network
23. DURABLE MEDICAL EQUIPMENT	Plan pays 70%; maximum benefit is $2,000 per calendar year, pre-authorization required.	Not covered
24. HEARING AIDS	Medically necessary hearing aids prescribed by a Denver Medical Care Network Provider are covered every five years in network. For adults age 18 and over, there is a $1,500 benefit maximum every 5 years. Charges exceeding the $1,500 hearing aid maximum benefit, are the responsibility of the member. Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under office visits and the applicable copayment applies. Hearing aids do not apply to the annual DME limit.	Not covered
25. PROSTHETICS	Plan pays 70%. No maximum benefit, does not apply to annual DME limit.	Not covered
26. ORTHOTICS	Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but must pay out-of-pocket for the orthotic and submit the receipt for reimbursement from DHMP.	
27. OXYGEN	100% covered; Equipment: 30% coinsurance, does not apply to DME maximum.	Not covered
28. ORGAN TRANSPLANTS	$1,000 copay per admission/individual. Only covered at authorized facilities. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants. Pre-authorization required.	Not covered
29. HOME HEALTH CARE	100% covered. Pre-authorization required.	Not covered
30. HOSPICE CARE	100% covered. Pre-authorization required.	Not covered
31. SKILLED NURSING FACILITY CARE	100% covered. Maximum benefit is 100 days per calendar year at authorized facility. Pre-authorization required.	Not covered
32. DENTAL CARE	Not covered except for fluoride varnish at PCP visit for children.	Not covered

1 Schedule of Benefits

	In Network	Out-of-Network
33. VISION CARE	Routine visual screening examinations are not covered. Other ophthalmology services are covered as referred by your PCP and provided by a network provider.	Not covered
34. CHIROPRACTIC CARE	$20 copay per visit. Maximum benefit is 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered
35. SIGNIFICANT ADDITIONAL COVERED SERVICES	Autism Services: Expanded services will be available with cost sharing based on type of service. Cochlear implants are now covered for children under age 18. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply. • **Curves Wellness program**. DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least 8 times per month • **Snap Fitness discount** • **Weight Watchers Discount**. DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • **Jenny Craig discount**: members receive a discount on enrollment and 25% off monthly program costs. • **eLearning module for parents-to-be**. Online childbirth classes, free of charge to members • **NEW!** Take Control of Your Health incentive plan	Not covered
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes, except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN.	Not covered
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Not covered

If you have a life or limb-threatening emergency, call 911 or go to the closest hospital emergency department or nearest medical facility.

DHMP, Inc. has an access plan which will be made available to members at their request by calling Member Services at 303-602-2100.

Prior authorization is required for, but not limited to, the following services:

Durable Medical Equipment, home health care, including IV therapy, hospital admissions, including substance abuse-related admissions, outpatient surgery, prescription drugs that require pre-authorization as listed in the DHMP formulary (DHMP formulary can be found on our website at www.denverhealthmedicalplan.com), skilled nursing facility admissions, transplant evaluations and procedures, and hospice care. Contact your Primary Care Physician or Specialist to request these services.

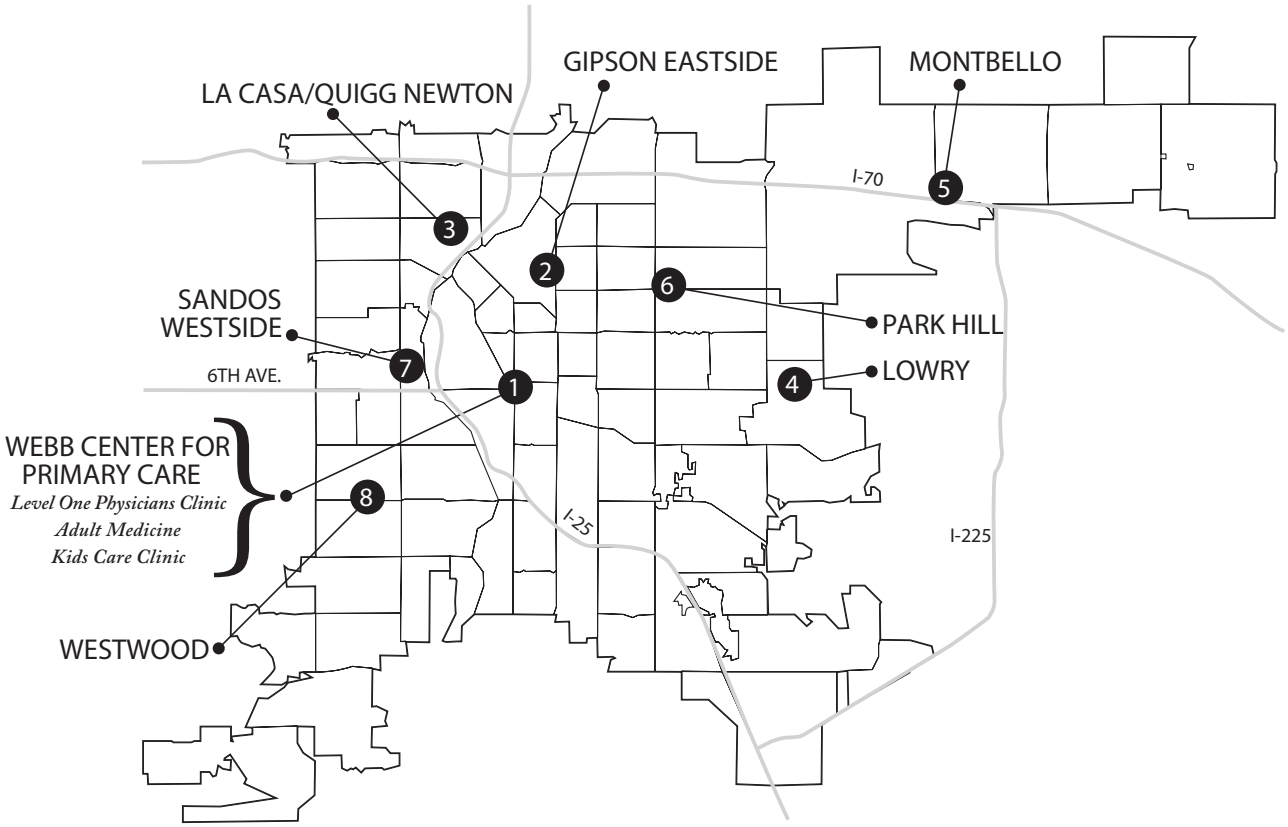
January 2013

ATTENTION DHMP MEMBERS
Career Service Authority and
Denver Employees Retirement Plan
Non-Medicare Primary

The information contained in this Member Handbook explains the administration of the benefits of Denver Health Medical Plan Inc., (DHMP) a state licensed health maintenance organization (HMO). This Member Handbook is also considered your Evidence of Coverage document. Information regarding the administration of DHMP benefits can also be obtained through DHMP marketing materials, and by contacting the DHMP Member Services Department at 303-602-2100 or 800-700-8140. In the event of a conflict between the terms and conditions of this Member Handbook and any supplements to it and any other materials provided by DHMP, the terms and conditions of this Member Handbook and its supplements will control.

Coverage for Employees of the City and County of Denver and non-Medicare retirees of Denver Employees Retirement Plan as described in this Member Handbook commences January 1, 2013 and ends December 31, 2013.

3 Contact Us



FAMILY HEALTH CENTERS

WELLINGTON WEBB CENTER FOR PRIMARY CARE
301 W. 6th Ave.

LEVEL ONE PHYSICIANS CLINIC	303.602.8270
ADULT MEDICINE CLINIC	
Burgundy	303.602.8070
Green Team	303.602.8080
KIDS CARE CLINIC	303.602.8340
Rx PHARMACY	303.602.8500

Rx GIPSON EASTSIDE
501 28th St.	303.436.4600
Pharmacy	303.436.4090

Rx LA CASA/QUIGG NEWTON
4545 Navajo	303.602.8700
Pharmacy	303.602.8700

LOWRY
1001 Yosemite St.
Suite 100 303.436.4545

Rx MONTBELLO
12600 E. Albrook Dr.	303.602.4000
Pharmacy	303.602.4025

PARK HILL
4995 E. 33rd Ave. 303.602.3720

Rx SANDOS WESTSIDE
1100 Federal Blvd	303.436.4200
Pharmacy	303.436.4200

WESTWOOD
4320 W Alaska Ave 720.956.2900

HOSPITAL

DENVER HEALTH MEDICAL CENTER
777 Bannock St. 303.436.6000

ADULT URGENT CARE WALK-IN CLINIC
777 Bannock St. 303.602.2822

PEDIATRIC URGENT CARE CLINIC
777 Bannock St. 303.602.3300

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5 Eligibility

5.1 Who is Eligible

You are eligible to participate in the Denver Health Medical Plan-Denver Medical Care if you are:

A regular, full-time or eligible part-time employee with the City and County of Denver.

A non-Medicare retiree in the Denver Employee Retirement Plan (DERP)

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

Your spouse as defined by applicable Colorado State law (including common-law spouse or same sex domestic partner) if;

A child married or unmarried until their 26th birthday as long as they are not eligible for health care benefits through their employer

An unmarried child of any age who is medically certified as disabled and dependent upon you.

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

For coverage under a qualified medical child support order or other court order, you must provide a copy of the order.

Eligible dependents living outside of the Network Area must use Denver Medical Care Network providers for their medical care, except for urgent/emergency care.

For a common-law spouse or same sex domestic partner, you must complete the appropriate paperwork (affidavit) and return it to your employer. This form is available from your employer or the DHMP Member Services Department.

You may not participate in this plan as both an employee and as a dependent.

You may enroll in DHMP without regard to physical or mental condition, race, creed, age, color, national origin or ancestry, handicap, marital status, sex, sexual preference, or political/religious affiliation. No one is ineligible due to any pre-existing health condition. DHMP does not discriminate with respect to the provision of medically necessary covered benefits against persons who are participants in a publicly financed program.

5.2 Enrollment

Initial Enrollment - You and your eligible dependents must enroll in DHMP within the first 30 days of your employment.

Open Enrollment - "Open enrollment" is an annual period of time during which employees may enroll in their employer's health insurance plan if they have not already done so, or may change from one health insurance option to another. You and your eligible dependents may enroll in DHMP during your employer's annual open enrollment period.

Special Enrollment - The occurrence of certain events triggers a special enrollment period during which you and/or eligible dependents (depending on the event) can enroll in DHMP. In each case, you and/or your eligible dependents must enroll within 31 days after the event.

Events that Trigger a Special Enrollment Period:

(1) **Loss of other creditable coverage:** If you were covered under other creditable coverage at the time of the initial enrollment period and lose that coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward such coverage, you may request enrollment in DHMP.

If an eligible dependent was covered under other creditable coverage at the time of the initial enrollment and loses

the coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward such coverage , your eligible dependent may request enrollment in DHMP if you are a member of DHMP.

(2) **Court Order:** If you are a DHMP member and a court orders you to provide coverage for a dependent under your health benefit plan, you may request enrollment in DHMP for your dependent.

(3) **New Dependents:** If you are a DHMP member and a person becomes a dependent of yours through marriage, birth, adoption, or placement for adoption, you may request enrollment of such a person in DHMP. In such a case, coverage will begin on the date the person becomes a dependent.

(4) **Newborn Children**: Your newborn child(ren) is (are) covered for the first 31 days after birth. For coverage to continue beyond the first 31 days, you must complete and submit an enrollment change form within those first 31 days to add your newborn child(ren), and pay the required premiums. The form is available from your employer. For additional information, call Member Services at 303-602-2100 or 800-700-8140.

Deletion of Dependents (changes in eligibility)

You must inform the DHMP Member Services Department within 31 days if a death, divorce, marriage or other event occurs which changes the status of your dependents. Those who are no longer eligible will lose coverage under the Plan, unless they qualify for continuation or conversion coverage (see section 12).

Dependents of Dependents (Grandchildren)

Children of a dependent are not covered for any period of time, including the first 31 days of life, unless court-ordered custody is awarded to the DHMP subscriber. You must provide a copy of the court order to DHMP along with the enrollment form.

5.3 When Coverage Begins

New Employees - If you are a new employee, have completed the DHMP enrollment process and paid the premiums required for coverage, your coverage begins on the first day of the calendar month following the month in which you began work. Coverage for your enrolled dependents begins when your coverage begins.

Open Enrollment - If you select DHMP during an annual open enrollment period, your coverage begins on January 1 of the following year. Coverage for your enrolled dependents begins when your coverage begins.

Newborn Children - Your newborn children are covered for the first 31 days after birth. You must complete and submit an enrollment change form within 31 days of birth to add your newborn children, and pay the required premiums, for coverage to continue beyond the first 31 days.

Other New Dependents - If you enroll any other new dependent, such as a new spouse, an adopted child or child placed for adoption, within 31 days of marriage, adoption or placement for adoption, coverage will be retroactive to the date of the event causing the change to dependent status.

Confined Members - If a member is confined to a medical facility at the time coverage begins and the member had previous coverage under a group health plan, the previous carrier will be responsible for all covered costs and services related to that confinement. DHMP will not be responsible for any services or costs related to that confinement. However, should any services be required that are not related to the original confinement, DHMP will be responsible for any services that are covered as stated in Section 7 - Benefits/Coverage. If the member is confined to a medical facility and was not covered by a group health plan when DHMP coverage began, DHMP will be responsible for the covered costs and services related to the confinement from the time coverage begins.

5.4 When Coverage Ends

Your coverage will end at 11:59 p.m. on the last day of the month in which you become ineligible.

A member may become ineligible when:

- A newborn dependent, new spouse, adopted child or child placed for adoption is not enrolled within the first 31 days of birth, marriage, adoption or placement;
- You are no longer a regular, full-time or eligible part-time employee who is actively employed for an enrolled employer group, unless you qualify for continuation or conversion coverage (see section 12);
- You retire and do not select DHMP under your employer's retirement plan;
- You are a dependent who no longer meets eligibility requirements, unless you qualify for conversion or continuation coverage (see section 12);

- You exhaust any continuation coverage for which you were eligible;
- You no longer pay the monthly premium required for continuation coverage;
- Your employer terminates coverage under the Plan;
- Your employer fails to make the required premium payments;
- You commit a violation of the terms of the Plan (see section 5.5).

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

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

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

Medicare Eligibility for Age or Disability Eligible Employees (Actively Working)

If you become eligible for Medicare by reason of age or disability while covered on this Plan, you must enroll in Medicare Part A. During any waiting period for Medicare coverage to begin (usually 24 months for disability), your coverage under this Plan will continue unchanged. Once the waiting period is over, you must make one of the following two choices:

1. Continue your coverage with DHMP while you are an eligible current employee. If you do so, DHMP will provide and pay for benefits as if you were not eligible for or enrolled in Medicare, i.e., DHMP will be your primary coverage. Medicare will pay for costs not paid by DHMP, i.e., Medicare will be your secondary coverage.
2. Select Medicare as your coverage while you are an eligible current employee. If you do so, your coverage with DHMP will terminate, as required by law. However, your covered dependents may be eligible for continuation coverage. See Section 12 for more information about continuation coverage. You should consider enrollment in Medicare Part B when Medicare is your only coverage.

Retired Employees

If you become eligible for Medicare by reason of age, your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. Call Member Services for details. The coverage of your dependents will also terminate. However, your covered dependents may be eligible for continuation coverage. See Section 12 for more information about continuation coverage.

If you become eligible for Medicare before age 65 by reason of disability and are covered on this Plan as a retiree, you must enroll in Medicare Part A. During any waiting period for Medicare coverage to begin (usually 24 months for disability), your coverage under this Plan will continue unchanged. Once the waiting period is over, Medicare will be your primary coverage. Your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. You will be responsible for paying the Medicare Part B premium. Call Member Services for more details.

If you continue on this Plan, your dependents may also continue on this Plan, with benefits unchanged. If you choose Medicare coverage only, the coverage for your dependents on this Plan will terminate. However, your covered dependents may be eligible for continuation coverage. See Section 12 for more information about continuation coverage.

The following information is applicable to individuals eligible for Medicare due to End Stage Renal Disease (ESRD).

Medicare Eligibility for End Stage Renal Disease (ESRD) Eligible Employees and Retirees

If you become eligible for Medicare before age 65 by reason of end stage renal disease (ESRD) and are covered on this Plan, you must enroll in Medicare Part A but DHMP will continue to provide and pay for benefits as if you were not eligible for or enrolled in Medicare, i.e., DHMP will be your primary coverage, for a period of 30 months after your you are eligible for Medicare – this period is called the coordination period because Medicare will coordinate with DHMP coverage and may pay for costs not paid by DHMP. Once the coordination period is over (or sooner if you are no longer an eligible employee), Medicare will be your primary coverage. If you are an Eligible Employee (actively working), you may continue your coverage under this Plan. If you do so, this Plan will be your secondary coverage and will pay costs not paid by Medicare Parts A and B, such as the Medicare Parts A and B deductibles and coinsurance amounts. One condition of secondary coverage under this Plan is that you must enroll in Medicare Part B. If you become eligible for Medicare by reason of end

stage renal disease (ESRD) you must enroll in Medicare Part B or you will be terminated from the plan. You will be responsible for paying the Medicare Part B premium but you may be eligible for reimbursement of the Part B premium amount from your former employer or the Plan. If you are a Retiree, when Medicare is your primary coverage, your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. Call Member Services for more details. There is no requirement to sign up for Medicare Part D.

5.5 Special Situations: Termination of Coverage

Under certain circumstances, your coverage or that of one or more of your dependents, may be terminated by DHMP. These circumstances are described below. You may use the complaint and appeal process available through DHMP if you feel there is a valid reason why coverage should not be terminated.

Non-Payment of Copayments - If a member does not pay required copayments or does not make satisfactory arrangements to pay copayments, DHMP may terminate the member with not less than 31 days written notice.

Inappropriate Behavior - If a member's behavior is disruptive, unruly or abusive to the extent that the ability of DHMP or a provider to render services to the member or other members is impaired, DHMP may terminate the member upon 31 days written notice. When possible, DHMP will attempt to resolve the problem, including the use of the complaint process. Behavior resulting from mental illness or reaction to treatment or medication will be taken into consideration.

False or Misleading Information - If a member attempts to obtain benefits under DHMP by means of false, misleading, or fraudulent information, acts or omissions for themselves or others, DHMP may terminate the member's coverage upon seven days written notification.

Misuse of Identification Card - The DHMP identification card is solely for identification purposes. Possession of the card does not ensure eligibility and/or rights to services or benefits. The holder of the card must be a member for whom all premiums under the Plan have been paid. If a member allows the use of his/her DHMP identification card by any other person, DHMP may terminate the member's coverage upon seven days written notice. Payment for services received as a result of the improper use of a DHMP identification card is the responsibility of the individual who received the services.

5.6 Special Situations: Extension of Coverage

Medical or Personal Leaves of Absence - If you are on an approved medical or personal leave of absence, including leave under the Family and Medical Leave Act, coverage will continue in accordance with your employer's policies and procedures.

Military Leave of Absence - If you are on an approved military leave of absence, coverage may continue for the duration of the leave. Payment must be made in accordance with your employer's policies and procedures.

Standard Leave of Absence - A member who elects to take authorized Standard Leave of Absence may be eligible for coverage as permitted by Career Service Rules. The Family Medical Leave Act of 1993 (FMLA) allows a worker up to 12 weeks of leave under certain circumstances.

6 How to Access Services and Obtain Approval of Benefits

6.1 Welcome to the Denver Health Medical Plan, Inc.

At Denver Health Medical Plan, Inc. (DHMP), our main concern is that you receive quality health care services.

As a member of DHMP's Medical Care Plan, you must receive your health care services within the Denver Medical Care Network and you will pay small copayments for most services.

Your basic membership obligation is to consult with your primary care provider (PCP) before seeking most health care services.

The Denver Medical Care Network includes: Denver Health and Hospital Authority and the Denver Health and Hospital Authority providers located on the Denver Health campus, as well as Denver Health and Hospital Authority neighborhood health care facilities that are conveniently located throughout the Denver metropolitan area. Denver Health offers a privately insured clinic, Level One Physicians Clinic located on the main Denver Health and Hospital Authority campus. Please refer to your Denver Medical Care provider directory for a complete listing of providers. A map of clinic locations can be found at the beginning of this book.

Please see the Summary of Benefits in Section 1 for a breakdown of copayments.

6.2 Member Handbook

This handbook contains information that will enable you to use DHMP efficiently and effectively, and help you to get the most from your health plan. This handbook supercedes all previous handbooks. Benefits and procedures may change from time to time so it is important that you use the most recent handbook as your reference. This handbook serves as your evidence of coverage. If you have a question regarding the information in this handbook, please contact the DHMP Member Services Department at 303-602-2100 or 800-700-8140.

6.3 Receiving Care through Denver Health Medical Plan, Inc.

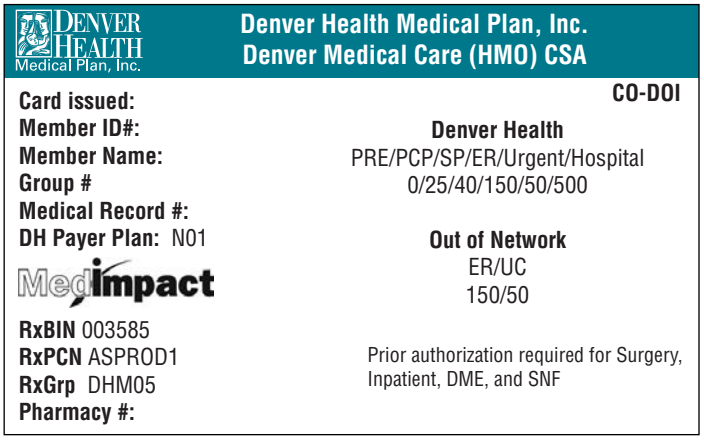
When you join DHMP, you will receive your care within the Denver Medical Care Network.

Here are some things you can do to get quality service:

- Carry your DHMP identification card and present it wherever you receive health care services. Always bring a picture ID to your appointment.
- Select your primary care provider (PCP) right away and call your PCP first when you think you need care (except if there is a life or limb threatening emergency). Call the Member Services Department at 303-602-2100 or 800-700-8140 to select your PCP. The provider directory is located online at www.denverhealthmedicalplan.com.
- Become familiar with the benefits that are covered under the plan.

Your DHMP Identification Card

Keep your DHMP identification card with you at all times. Before receiving medical or prescription services, you must show your DHMP identification card. If you fail to do so, or misrepresent your membership status, claims payment may be denied.



Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is the practitioner (physician, nurse practitioner, or physician assistant) you choose from the Denver Medical Care Network who supervises, coordinates and provides your initial and basic care, initiates referrals for specialist care and maintains the continuity of your care. The relationship between you and your PCP is the key to receiving health care benefits through DHMP. PCPs can be Family Practice, Internal Medicine or Pediatric practitioners.

Your PCP is your partner in your personal health care management, providing most of your care and coordinating other care as necessary.

Services should be provided or referred by your PCP. You do not need a PCP referral for life or limb-threatening emergency care or urgent care in or out-of-network, you can self-refer for in network outpatient mental health care, routine eye exam, chiropractic care and OB/GYN care for women. When living or traveling outside of the network, only emergencies, urgent care services and your prescription costs will be covered in network.

Selecting Your Primary Care Provider (PCP)

You need to choose a PCP in order to receive DHMP covered benefits. Each family member may select a different PCP. If you have not yet chosen a PCP, please do so right away by calling the Member Services Department at 303-602-2100 or 800-700-8140. A Member Services Representative can help you select a PCP. Your provider directories are available online at www.denverhealthmedicalplan.com.

Working With Your Primary Care Provider (PCP)

When you need non-emergency medical care, call your PCP and he/she will provide necessary treatment and make referrals to specialists when appropriate. Your PCP may refer to any specialist in the Medical Care network. If you require ongoing care from a specialist, your PCP may issue a standing referral within the Denver Medical Care Network for a period of up to one year. The standing referral will allow you to see the specialist for treatment of a specified condition, during the stated period, without having to get a referral from your PCP each time a visit to the specialist is required. Even if you have a standing referral, you must continue to see your PCP for your primary care. Referrals to in network specialists must be initiated by your PCP, but do not require authorization by DHMP. If you believe that a second opinion is needed about a course of treatment that has been recommended for you by a specialist or your PCP, preauthorization for the second opinion may be initiated by your PCP or your specialist.

You may self-refer for emergency care, urgent care, and for the following services in the DHMP Medical Care network: OB/GYN care, outpatient mental health care and Columbine Chiropractic care.

If you choose to see a provider or specialist who does not participate in the Denver Medical Care Network without a referral and without authorization, you will be responsible for all charges, including charges for hospital care. DHMP has no obligation to pay these charges, which can accumulate much more rapidly than you anticipate. Note: In a case of emergency, you may go to any physician or facility, in or out-of-network.

Changing Your Primary Care Provider (PCP)

You can change your PCP at any time by calling the Member Services department at 303-602-2100 or 800-700-8140. The change will take effect the first day of the month following your call.

When a PCP leaves that you have received treatment from the Denver Medical Care Network will notify you in writing. You will need to pick a new PCP or one will be assigned.

Contact your new PCP before you receive further specialist care.

Access Plan

DHMP has an Access Plan that lists all hospitals and other providers in the network and explains, in detail, DHMP's referral procedures, grievance procedures and emergency coverage procedures. You may request to see the Access Plan by calling the Member Services Department at 303-602-2100 or 800-700-8140.

When you are out of town

If you plan to be outside the DHMP service area and need your prescription filled while you are gone, we have a broad network of pharmacies across the United States to accommodate you. Please check with Member Services for more information.

Change of address

If you change your name, mailing address, or telephone number, call your Benefits Manager.

6.4 How to Get Help

If you have any questions or need to contact DHMP for any reason, call the Member Services Department 303-602-2100 or 800-700-8140 for assistance. TTY/TDD call 303-602-2129.

6.5 Advance Directives

Federal law directs that any time you are admitted to any health care facility, or served by certain organizations that receive Medicaid or Medicare money, you must be given information about Colorado's laws concerning your right to make health care decisions. Such decisions include the right to consent to (accept) or refuse any medical care or treatment, and the right to give advance directives. Advance directives are written instructions concerning your wishes about your medical treatment. These are important health care decisions and they deserve careful thought. It may be a good idea to discuss them with your doctor, family, friends, or staff members at your health care facility, and even a lawyer. You can obtain more information about advance directives, such as living wills, medical durable powers of attorney, and CPR directives (do not resuscitate orders) from your PCP, local hospital, or lawyer. You are not required to have any advance directives to receive medical care or treatment. Advance Directive forms are available on the DHMP web site at www.denverhealthmedicalplan.com.

7.1 Benefits

Your DHMP Benefits

When you join DHMP, the quality of your care is monitored through our Quality Improvement Program.

DHMP evaluates new medical technologies and the new application of existing technologies for inclusion in the benefit package, including medical procedures, pharmaceuticals and devices.

It is important that you understand which benefits and copayment obligations apply to you. When in doubt, call the DHMP Member Services Department at 303-602-2100 or 800-700 8140. DHMP is the best source for information about your health care plan benefits.

Member Newsletter

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

Behavioral Health and Wellness Program

As a DHMP member, you have access to our Behavioral Health and Wellness program. The program includes health coaches that can assist you with healthy lifestyle choices, managing chronic conditions, and navigating through the DH system. For more information, call Behavioral Health & Wellness at 303-602-2188.

7.2 Covered Medical Services

Chiropractic Services

Chiropractic care is covered when received from a Denver Medical Care Network provider. Please refer to the Columbine Chiropractic Plan Directory for a list of participating Chiropractors. Self-referral is allowed. Service exclusions (e.g. acupuncture, massage therapy) may apply. Acupuncture and massage therapy are NOT a covered benefit. However, the plan does offer a discount program for these services. See Special Programs on the web site at: www.denverhealthmedicalplan.com or look in your Quick Reference Guide.

In network: $20 copay per visit, Columbine Chiropractic only

Out-of-network: Not covered

Benefit Maximum: 20 visits per calendar year

Clinic (Outpatient) Services

- **Office Visits**

  Primary Care Services provided by your PCP are covered. Referrals to specialists, unless otherwise specified in this handbook, must be made by your PCP. Phone consultations are not subject to copayments. For information about preventive care services, please refer to the *Preventive and Health Maintenance Medical Management* section of this book.

  Allergy, immunization and other injections given by a nurse received in an office setting when no other services are provided are not subject to office visit copayments.

  Primary Care:

  In network: $25 per visit

  Out-of-network: Not covered

  Speciality Care:

  In network: $40 per visit

  Out-of-network: Not covered

- **Clinics Outside the Health Plan Network**:

Specialty outpatient care outside of the Denver Medical Care Network may be covered if:

(1) The type of care is not provided within the Denver Medical Care Network, and

(2) You receive a referral from your PCP, and

(3) The referral is approved (authorized), in advance, by DHMP.

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

When living or traveling outside of the Denver Metropolitan area, only emergencies, urgent care services, and prescriptions in network pharmacies will be covered.

Diabetic Education and Supplies

If you have elevated blood glucose levels and have been diagnosed as having diabetes by an appropriately licensed health care professional, you are eligible for outpatient self-management training and education, as well as coverage of your diabetic equipment and supplies, including glucometers, test strips, insulin and syringes. These supplies are provided by your pharmacist with a prescription from your physician. Insulin pumps are covered through the DME benefit, which covers a maximum of $2000 per calendar year for all of your durable medical equipment (DME) needs.

Dietary and Nutritional Counseling

Coverage for dietary counseling is limited to the following covered situations:

- New onset diabetic.
- Weight reduction counseling by a dietitian.

Durable Medical Equipment and Supplies

- **General**

  Durable medical equipment (DME) is covered if medically necessary and prior authorized by the DHMP Medical Management department. The prior authorization will specify whether the equipment will be rented or purchased. Rentals are authorized for a specific period of time. If you still need the rented equipment when the authorization expires, you should call your PCP and request that the authorization be exten ded. Except for certain supplies, such as oxygen the copayment for DME is as stated in the Summary of Benefits. All DME must be obtained from a Denver Medical Care Network provider. Repair of equipment is covered with no additional copay if the repair is needed due to normal usage; repair due to misuse/abuse is not covered. Replacement of equipment due to normal usage is covered and the DME benefit maximum and copay apply.

  You are responsible for the entire cost of lost, stolen or damaged equipment (other than normal usage).

  In network: 30% copay of total cost

  Out-of-network: Not covered

  Benefit Maximum: $2000 per member per calendar year

All of the specific types of DME described below are subject to the general conditions of coverage above unless otherwise stated.

- **Braces**

  Braces for scoliosis and braces for an acute condition (within six months of a new injury or surgery) are covered.

- **Dressings/Splints/Casting/Strapping**

  Dressings/splints/castings/strappings that are given to you by a provider are covered and no copayment is required. The cost of purchased dressings/splints/castings/strappings apply to the DME benefit maximum of $2000 per calendar year and the 30% copay applies. NOT COVERED Out-of-Network.

- **Oxygen/Oxygen Equipment**

  Equipment for the administration of oxygen is covered and subject to DME copayments. Oxygen is covered, and no copayment is required. THE COST OF OXYGEN EQUIPMENT AND OXYGEN WILL NOT APPLY TO THE ANNUAL DME BENEFIT MAXIMUM.

Early Intervention Services

Early intervention services are covered for an eligible dependent from birth to age 3 who has, or has a high probability of having, developmental delays, as defined by state and federal law, and who is participating in Part C of the federal Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq.

Early intervention services are those services that are authorized through the eligible dependent's individualized family service plan, including physical, occupational and speech therapies and case management. A copy of the individualized family service plan must be furnished to the DHMP Medical

Management department. All services must be provided by a qualified early intervention service provider who is in the DHMP Network, unless otherwise approved by Medical Management department.

No copayments apply to early intervention services.

Benefit Maximum: $6,361 for all early intervention services per calendar year.

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

Emergency Services

For life or limb-threatening emergencies, you should call 911 or go to the nearest hospital emergency department.

Services for the treatment of an emergency are covered. See definition of "Emergency," Chapter 9. If you are admitted to the hospital directly from the Emergency Department, you will not have to pay the emergency department copayment, but will be responsible for the inpatient copayment.

In network: $150 copay per visit

Out-of-network: $150 copay per visit

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

Follow-up care following an emergency department visit must be received from a Denver Medical Care Network provider, unless you are traveling outside the Network Area and prior authorization is obtained. If you are admitted to a non-Denver Health hospital as the result of an emergency and then subsequently transferred to Denver Health, you will only be responsible for the copayment for the first inpatient hospital admission.

- **Ambulance Service**

  Medically necessary ambulance services related to the treatment of an emergency are covered.

  Use of ambulance services should be reported to DHMP as soon as reasonably possible, preferably within 48 hours, even if you are treated at Denver Health and Hospital Authority. Please call Medical Management department at 303-602-2140.

  In network: $450 copay per trip

  Out-of-network: $450 copay per trip
  This copayment is not waived if you are admitted.

- **Urgent Care Services**

  Urgent care services received within the Denver Medical Care Network are covered. Urgent care services are those required in order to treat and prevent a serious deterioration in health but which do not rise to the level of an emergency. After working hours you may also, call the NurseLine at 303-739-1261.

  In network: $50 copay

  Out-of-network: $50 copay

  If you are traveling or temporarily absent from the Denver area and need emergency or urgent care services, DHMP will pay out of-network providers directly or reimburse you for these services.

  Follow-up care after an emergency visit must be received from a Denver Medical Care Network provider, although if you are traveling outside the Denver area authorization can be obtained for one follow up visit. A separate copayment will be required. Notes: Travel expenses back to the Denver Medical Care Network Area are not a covered benefit.

Eye Examinations and Ophthalmology

- **Routine Visual Screening Exam**

  Routine visual screening examinations are not covered. Other ophthalmology services are covered as referred by your PCP and provided by a network provider.

  Artificial Eyes (see under Prosthetics).

  Exclusion: Optometric Vision Therapy/Treatment

Family Planning and Infertility Services

- **Family Planning Services**

  The following are covered if obtained from a provider in the Denver Medical Care Network:

  - Family planning counseling
  - Pre- and post-abortion counseling
  - Information on birth control
  - Diaphragms (and fitting)
  - Insertion and removal of intrauterine devices
  - Contraceptives (oral) (see Medicine/Pharmacy)

In network: Covered by office copay.

Out-of-network: Not covered.

You do not need a referral from your PCP to obtain services from any gynecologist in the Denver Medical Care Network. Specialist copays will apply.

- **Family Planning Procedures**:
  - Tubal ligations
  - Vasectomies
  - Abortions up to the 15th week of pregnancy

In network: Applicable copay

Out-of-network: Not covered

Vasectomies are covered. You must receive a referral from your PCP to a participating urologist, if the service is not provided by your PCP.
There are some limitations; please see exclusions.

- **Infertility Services**

In network: Not covered

Out-of-network: Not covered

Habilitative Services

Medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered even if the purpose of the therapy is to maintain functional capacity.

In network: $50 copay per visit

Out-of-network: Not covered

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy. See "Early Intervention Services" for the benefit maximum for therapies for children to age three.

Hearing Aids

For adults age 18 and over, there is a $1,500 benefit maximum. Charges exceeding the $1,500 hearing aid maximum benefit, are the responsibility of the member. Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under clinic visits and the applicable copayment applies. Hearing aids are no longer part of the DME benefit.

- **Adults**:

In network: Copay 30% of total cost with a maximum benefit of $1,500. Member responsible for amount over $1,500

Out-of-network: Not covered

- **Children** (Under age 18):

In network: No cost

Out-of-network: Not covered

Benefit Maximum: Not covered more frequently than every 5 years. Adult: $1,500; Children: No limitation

Cochlear implants are covered for children under 18 with prior authorization. The device is covered at 100%. Appropriate copay, will apply to surgical services associated with the device.

Home Health Care

Home health care provided by a Denver Medical Care Network home health care provider is covered. Coverage requires periodic assessment by your PCP. A referral by your PCP and prior authorization by DHMP are required.

- **Newborn and Post-partum**

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

- **Physical, Occupational and Speech Therapy**

Physical, occupational and speech therapy, as well as audiology services, in the home are covered when prescribed by your PCP or specialist and prior authorized by the DHMP Management. Periodic assessment and prior authorization are required to continue therapy beyond the time specified by the initial referral.

Generally, home physical therapy, occupational therapy and speech therapy and audiology services will be authorized only until maximum medical improvement is reached or the patient is able to participate in outpatient rehabilitation. However, early intervention services for children up to age three with developmental delays and medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered, even if the purpose of the therapy is to maintain functional

capacity. See "Early Intervention Services" for more detail about the therapies authorized.

- **Skilled Nursing Services**

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

- **Other Services**

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

  In network: 100% covered

  Out-of-network: Not covered

Hospice Care

Inpatient and home hospice services for a terminally ill member are covered when provided by an approved hospice program. Each hospice benefit period has a duration of three months. Hospice Services must be prior authorized by DHMP Medical Management department before you receive your care.

Hospice benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less. Any member qualifying for hospice care is allowed two 3-month hospice benefit periods. Should the member continue to live beyond the prognosis for life expectancy and exhaust his/her two 3-month hospice benefit periods, hospice benefits will continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, DHMP Medical Management department will work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care. Services and charges incurred in connection with an unrelated illness or injury are processed in accordance with the provisions of this Handbook that are applicable to that illness or injury and not under this section.

- **Home Hospice Care**

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

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

Any supplies outside of the usual and customary supplies must be prior authorized by the DHMP Medical Management department.

- **Hospice Facility**

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

  In network: 100% covered

  Out-of-network: Not covered

Hospital (Inpatient) Services

Any admission to a hospital, other than an emergency admission, must be to a Denver Medical Care Network hospital and must be prior authorized by the DHMP Medical Management department. Emergency hospitalization should be reported to DHMP at 303-602-2140 as soon as reasonably possible, preferably within 48 hours.

- Hospital services, including surgery, anesthesia, laboratory, pathology, radiology, radiation therapy, respiratory therapy, physical therapy, occupational therapy and speech therapy are covered. Oxygen, other gases, drugs, medications and biologicals (including blood and plasma) as prescribed are also covered. See Chapter 4 - General Exclusions for non-covered services.
- General inpatient nursing care is covered. Private duty nursing services are not covered. Sitters are covered only when medically necessary and prior authorized.
- Accommodations necessary for the delivery of medically necessary covered services are covered, including bed (semi-private room when available), meals and services of a dietitian; use of operating and specialized treatment rooms; and use of intensive care facilities.

  In network: $500 copay per admission, except for admissions for transplants.

  Out-of-network: Not covered

  Note: If you are admitted to a non-Denver Health hospital as the result of an emergency and then subsequently transferred to Denver Health, you will only be responsible for the copayment for the first inpatient hospital admission.

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

Immunizations

- There is no copay for immunizations. Immunizations for international travel, Hepatitis A and B, and Meningococcal vaccines will also be covered at no cost. Some international travel immunizations will only be covered at the Public Health Department at Denver Health. Prophylactic drugs for travel will be covered if prescribed by your PCP and if the drugs are on the DHMP formulary. Some immunizations can be received in your PCP's office, so before visiting the Public Health department at Denver Health, contact your PCP first for immunizations and prophylactic drugs.
- HPV vaccine is covered for eligible females and males in accordance with guidelines of the U.S. Department of Health and Human Services when ordered by your provider.
- Clinic visits for administration of immunization do not require a copayment. However, if the visit is a combination of the injection and a PCP, or specialist visit the required copayment will be requested.

Infusion Services

All infusion services including chemotherapy.

In network: $10 copay per visit

Out-of-network: Not covered

Injection Administration

In network: $20 copay per visit*

Out-of-network: Not covered

*The injection copay applies to complex injections that must be given by a physician. An allergy shot, immunization or any injection given by a nurse will not require a copayment. However, if the visit is a combination of the injection and a PCP or specialist visit the required copayment will be requested.

Laboratory and Pathology Services (Outpatient)

All medically necessary laboratory and pathology services and testing ordered by your PCP or specialist or resulting from emergency care are covered.

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

In network: 100% covered

Out-of-network: Not covered

Maternity Care

- **Prenatal Care**

  Office visits, physician services, laboratory and radiology services necessary for pregnancy, when such care is provided by a network provider, are covered. You may obtain obstetrical services from your PCP or any network obstetrician. You do not need a referral from your PCP to see a participating OB/GYN, physician, Certified Nurse Midwife or Nurse Practitioner. Expectant mothers are encouraged to limit travel out of the Denver Metro area during the last month of pregnancy. If a "high-risk" designation applies, mothers should limit non-emergency travel within two months of expected due date.

  In network: $35 copay per visit for all prenatal visits and the first post partum visit.
  Out-of-network: Not covered

- **Delivery (Vaginal or Cesarean)**

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

  Mother and child may have a minimum hospital stay of 48 hours following a vaginal delivery or 96 hours following a Cesarean delivery, unless mother and attending physician mutually agree to a shorter stay. If 48 hours or 96 hours following delivery falls after 8:00 p.m., the hospital stay will continue and be covered until at least 8:00 a.m. the following morning.

  In network: $300 copay per delivery admission

  Out-of-network: Not covered

  Limitations: Home deliveries are not covered

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

Medical Food

Medical food is covered for metabolic formulas to treat enzymatic disorders caused by single gene defects. Enteral (by tube) or Parenteral (by intravenous infusion) nutrition– if member has non-function or disease of the structures that normally permit foot to enter the small intestine or impairment of small bowel that impairs digestion and absorption of an oral diet.

Exclusions:

Standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; intolerances to soy formulas or protein hydrolysates; prematurity; or low birth-weight

- Food thickeners
- Dietary and food supplements
- Lactose-free products; products to aid in lactose digestion
- Gluten-free food products
- Weight-loss foods and formula
- Normal grocery items
- Low carbohydrate diets
- Baby food
- Grocery items that can be blenderized and used with enteral feeding system
- Nutritional supplement puddings
- High protein powders and mixes
- Oral vitamins and minerals

Mental Health Services

- **Inpatient Psychiatric/Mental Health Services**

  Inpatient psychiatric care is covered at a Denver Medical Care Network facility.

  Prior authorization is required for non-emergency admissions. Notification to DHMP should be made as soon as reasonably possible, preferably within 48 hours of an emergency admission.

  In network: Inpatient: $500 copay per admission

  Out-of-network: Not covered

- **Partial Hospitalization/Day Treatment**

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

  Virtual Residency Therapy is considered outpatient care and the outpatient copay applies for each day of service.

  In network: $40 copay per day, whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

- **Outpatient Psychiatric/Mental Health Services**

  Individual and group psychotherapy sessions are covered. You may obtain mental health services from any mental health professional in the Denver Medical Care Network or in the Cofinity network without a referral from your PCP.

  In network: $40 copay per visit, whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

  There is no copayment for phone consultations with your mental health provider.

- **Marital Counseling, Stress Counseling and Family Therapy**

  Marital and couples counseling, family therapy and counseling for stress-related conditions are covered. You may obtain these services from any mental health professional in the Denver Medical Care Network without a referral from your PCP.

  In network: $40 copay per visit, Whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

  No benefit maximum

- **Biologically-based Mental Illnesses and Mental Disorders**

  DHMP will provide coverage for the treatment of biologically-based mental illnesses and mental disorders that is no less extensive than for any other physical illness. Biologically-based mental illnesses are: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder. "Mental Disorders" are defined as post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa, and anorexia nervosa. Residential treatment, including for bulimia nervosa and anorexia nervosa, is not a covered benefit.

  Inpatient/In network:$500 copay per admission

  Outpatient: $50 copay per visit, whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

  No benefit maximum

Newborn Care

All in-network hospital, physician, laboratory and other expenses for your newborn are covered, including a well child examination in the hospital. During the first 31 days of your newborn's life, benefits consist of coverage for any injury or sickness treated by a Denver Medical Care Network provider, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, regardless of any limitations or exclusions that would normally apply under the plan. Applicable copay will apply. You must enroll your newborn in DHMP during the first 31 days of life for coverage to continue beyond the first 31 days. Refer to the *Eligibility Section*. Children of a dependent child are not covered for any period of time, even the first 31 days.

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

ment. If a dental insurance policy is in effect at the time of birth, or is purchased after the birth of a child with cleft lip or cleft palate or both, the Plan will follow coordination of benefit rules.

Observational Hospital Stay

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

An observational hospital stay is covered with prior authorization, or if it resulted from an emergency department visit. If you are admitted into Observation after receiving services in the emergency department, you will not have to pay the emergency department copayment, but you will be responsible for the observational stay copayment.

In network: $150 copay per observational stay

Out-of-network: $150 copay per observational stay

Orthotics

Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but must pay out-of-pocket for the orthotic and submit the receipt for reimbursement from DHMP. Benefit Maximum for Shoe Orthotics: $50 per calendar year. (See Section 10.1: "How to File a Claim" for information on how to get reimbursed.)

Ostomy Supplies

Colostomy, ileostomy and urostomy supplies are covered.

Pharmacy Benefits

DHMP provides a drug coverage benefit. Depending upon where you have your prescription filled, copays and restrictions may vary. Please see the Pharmacy Benefits chart below.

- Participating Pharmacies

Your copay will always be less when you fill your prescriptions at one of the many Denver Health Pharmacies. Denver Health Pharmacies offer a "Discounted Copay List" for DHMP members. You can find the current list of eligible drugs at www.denverhealthmedicalplan.com or by calling Member Services.

Remember, in order to fill a prescription at a Denver Health Pharmacy, it must be written by a Denver Health Provider.

Denver Health Refill Request Line
1-866-347-3345

Denver Health Pharmacy by Mail (requires credit card registration/order form)
303-602-2326

Primary Care Pharmacy
303-602-8500
301 West 6th Avenue

Gipson Eastside Pharmacy
303-436-4600
501 28th Street

ID/HIV Clinic Pharmacy
303-602-8710
605 Bannock Street

La Casa/Quigg Pharmacy
303-602-8700
4545 Navajo Street

Montbello Pharmacy
303-602-4025
12600 Albrook Drive

Sandos Westside Pharmacy
303-436-4200
1100 Federal Blvd

You may take your prescriptions to any designated MedCare® (MedImpact) Pharmacy such as Albertsons, King Soopers, Safeway, Rite-Aid, Target, Walgreens, but your copay will be higher. You can find a pharmacy near you by visiting our website at www.denverhealthmedicalplan.com or by calling Member Services.

- Formulary

DHMP provides a list of covered drugs known as the Denver Health Medical Plan Formulary. The formulary assists providers in selecting clinically appropriate and cost-effective drugs.

You can view the current formulary at www.denverhealthmedicalplan.com under the Employer Group/CSA/DERP/DPPA or you can call Member Services to request a printed copy.

If a restriction is noted on the formulary or you do not see your drug listed, please talk to your provider. There may be a generic or a formulary approved alternative drug. Your provider may request an exception by calling or submitting a Prior Authorization Request (PAR) to the Managed Care Pharmacy Services Department. All requests are reviewed on a case-by-case basis.

Generic and Brand Copays

You can save money by using generic drugs which have lower copays. Generic drugs are FDA-approved for safety and effectiveness and are manufactured using the same strict standards that apply to the brand name alternative. If you request a brand name drug when a generic is available, you must pay the higher, brand copay plus the difference in cost between the

generic and brand name drug.

Refill Prescriptions

It is best to call at least 3-5 days before you need your prescription. Your prescription is eligible for refill once 75% has been used. This is calculated using the original prescription directions. If the directions have changed please contact your pharmacy or provider for an updated prescription. If the prescription directions change or you need a refill earlier, please be sure to let your pharmacy know ahead of time. This will allow the pharmacy time get authorization if needed.

When you use Denver Health Pharmacies you may order your prescriptions using the automated refill line 1-866-DH-REFIL (866-347-3345) or by visiting www.denverhealthmedicalplan.com website.

Mail Order Pharmacy

Another way to save time and money is by using a mail order pharmacy. You can have certain prescriptions delivered to your home and only pay 2 copays (instead of 3 copays) for a 90-day supply. Ask your provider to write the prescription for a 90-day supply so the pharmacy can fill the full amount.

Denver Health Pharmacy by Mail
Offers lower copays
Call Pharmacy Customer Service at:
303-602-2326 or toll free at 1-866-347-3345
Monday-Friday, 9 am - 5 pm

Prescriptions must be written by a DHMC provider

90-Day Supply at retail

You can also purchase a 90-day supply for certain maintenance medications at designated Choice 90 pharmacies. You will pay 3 copays for each 90-day prescription. You can find out if your drug and/or pharmacy are included by visiting our website at www.denverhealthmedicalplan.com or by calling Member Services.

	Discount Generic	Preferred Generic (Tier 1)	Preferred Brand (Tier 2)	Non-Preferred (Tier 3)
DH Pharmacy (30 day supply)	**$4**	**$10**	**$15**	**$30**
DH Pharmacy or Pharmacy Delivery by mail (90 day supply)	**$8**	**$20**	**$30**	**$60**
Non-DH Pharmacy (30 day supply) (Examples: King Soopers, Target, etc.)	**$8**	**$20**	**$30**	***$60**
Non-DH Pharmacy (90 day supply) (Examples: King Soopers, Target, etc.)	**$16**	**$40**	**$60**	***$120**

*Prior Authorization Required

Preventive and Health Maintenance Medical Management

DHMP has developed clinical and preventive care guidelines and health management programs to assist members with common health conditions, including diabetes management, asthma, and pregnancy care. For information, please call 303-602-2100 or visit our website at: www.denverhealthmedicalplan.com. Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the following chart for your cost-sharing that may apply to preventive care services received by a Denver Health provider. Please keep in mind the following:

- You should consult with your physician to determine what is appropriate for you.
- When you see a specialist for preventive and health maintenance services, the specialist copay will apply except for a woman who wishes to see an obstetrician, gynecologist, or certified nurse midwife for her well-woman exam.

Preventive Care Service	You Pay (for services from a Denver Health Provider)	Out-of-Network
Adult annual preventive care exams *As well as all screenings rated A or B by the U.S. Preventive Services Task Force (USPSTF) *Age-appropriate adult preventive care screenings including but not limited to:* • Cholesterol (lipid profile) screening • Mammograms • Screening colonoscopy/sigmoidoscopy	$0 copay/office visit There is no additional charge for these tests	Not covered
Well-woman exams including: • Medical history • Physical exam of pelvic organs including PAP test • Vaginal smear • Physical exam of the breasts • Rectal exam including FOBT • Consultation for birth control, if requested • Urinalysis	$0 copay/office visit	Not covered
Well-child care including routine examinations, blood lead level screenings, and immunizations	$0 copay/office visit	Not covered
Additional Newborn Examination *One newborn home visit during the first week of life if discharged less than 48 hours after a vaginal delivery or less than 96 hours after a cesarean-section delivery.*	$0 copay	Not covered
Routine immunizations – ordered by the provider and in accordance with national guidelines.	$0 copay *(Clinic visits for an allergy shot or immunization alone do not require a copay. If the visit is a combination of the injection and a nurse, primary care, or specialist visit, the required copay will be collected.)*	*Not covered*

* Each year members are allowed both an annual physical AND a well woman visit, both at the $0 copay.

Prosthetic Devices

Prosthetic devices designed to replace an arm or a leg are covered. Repair and replacement of the prosthetic device is covered unless needed because of misuse or loss. NOT COVERED out-of-network.

External breast prostheses and mastectomy bras are covered following mastectomy. NOT COVERED out-of-network.

- **Artificial Eyes**

Artificial eyes are covered. Artificial eyes will not be replaced if lost, stolen, or damaged.

Limitations: Cleaning and repair of artificial eyes is not a covered benefit.

In network: 30% of actual cost.
No maximum benefit. Does not accrue towards $2000 yearly limit.

Radiology/X-Ray Diagnostic and Therapeutic Services

- **Radiology and X-Ray Services**

All medically necessary radiology and x-ray tests, diagnostic services and materials prescribed by a licensed provider are covered, including diagnostic and therapeutic x-rays and isotopes. At Denver Health, mammograms can be scheduled at either the Radiology department or at the Women's Care van.

In network: No copay 100% covered

Out-of-network: Not covered

- **MRI and PET Scans**

In network: $100 copay

Out-of-network: Not covered

- **Radiation Therapy**

In network: $10 copay per visit.

Out-of-network: Not covered

Rehabilitation Services/Therapies (Outpatient)

Physical therapy, occupational therapy and speech therapy will be authorized only until maximum medical improvement is reached or the annual benefit is exhausted, whichever comes first. However, early intervention services for children up to age 3 with developmental delays are covered without regard to maximum medical improvement. See "Early Intervention Services". In addition, medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered even if the purpose of the therapy is to maintain functional capacity.

In network: $50 copay per visit.

Out-of-network: Not covered

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy. See "Early Intervention Services" for the benefit maximum for therapies for children to age three.

Skilled Nursing Facility/Extended Care Services

Extended care services at authorized skilled nursing facilities are covered. Covered services include skilled nursing care, bed and board, physical therapy, occupational therapy, speech therapy, respiratory therapy, medical social services, prescribed drugs, medications, medical supplies and equipment and other services ordinarily furnished by the skilled nursing facility. Prior authorization by the DHMP is required.

In network: No copay - 100% covered.

Out-of-network: Not covered

Benefit Maximum: 100 days per calendar year

Sleep Studies

Covered if provided at a network facility.

In network: $400 copay

Smoking Cessation

Talk to your PCP about smoking cessation. The Colorado Quitline has tools and resources to help including counseling and nicotine replacement such as patches or gum You can contact the Colorado Quitline at 1-800-QUIT-NOW. A formulary smoking cessation drug (generic form of Zyban) is available with a $0 copay; other medications such as Chantix require a prior authorization request but are also $0. You also have access to a HealthCoach who can assist and support you through the process. For more information, contact Member Services at 303-602-2100.

Specialized Treatment Facilities

- **Renal Dialysis**

Renal dialysis is covered if provided at a Denver Medical

Care Network facility. The member must submit an application to the Medicare program. See Section 2.4 "When Coverage Ends: Medicare Eligibility for ESRD."

In network: No copay - 100% covered.

Out-of-network: Not covered

Substance Abuse Services

Referral by your PCP and prior authorization by the DHMP Medical Management Department are required, except in the case of an emergency.

- **Drug and Alcohol Abuse - Detoxification**

  Emergency medical detoxification is limited to the removal of the toxic substance or substances from your system, including diagnosis, evaluation and emergency or acute medical care. In the event of an emergency, you should notify DHMP as soon as reasonably possible, preferably within 48 hours.

  In network: $500 copay

  Out-of-network: Not covered

- **Inpatient Substance Abuse Rehabilitation Services**

  Your admission and treatment must be in a Denver Medical Care Network facility and prior authorized by the DHMP Medical Management Department.

  In network: $500 copay

  Exclusions: Maintenance or aftercare following a rehabilitation program

- **Outpatient Substance Abuse Program Services**

  Substance abuse services that are provided to members who are living at home and receiving services at a network facility on an outpatient basis are covered. Members may self refer within the Denver Medical Care Network.

  In network: $40 copay

  Out-of-network: Not covered

Surgery Services

- **Inpatient Surgery**

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

  In network: $500 copay per admission, except for transplants.

  Out-of-network: Not covered

Outpatient Surgery

Surgical services at a Denver Medical Care Network hospital, outpatient surgical facility, or a physician's office are covered, including the services of a surgical assistant and anesthesiologist. Services must be prior authorized by the DHMP Medical Management Department.

In network: $200 copay per visit

Out-of-network: Not covered

- **Oral/Dental Surgery**

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

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

  - The child has a physical, mental or medically compromising condition; or
  - The child needs dental care for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; or
  - The child is extremely uncooperative, unmanageable, anxious or uncommunicative and the care cannot reasonably be deferred; or
  - The child has sustained extensive orofacial or dental trauma.

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

  With regard to children born with cleft lip or cleft palate or

both, see Newborn Care.

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

- **Breast Surgery**

  The Plan provides coverage for mastectomies and the physical complications of mastectomies, including lymphedemas. Breast reconstruction of the affected and non-affected side, by a network provider, as well as internal prosthetic devices are covered if prior authorized by the DHMP Medical Management Department. Medically necessary breast reduction is covered when prior authorized by the DHMP Medical Management Department. External prosthetic devices following mastectomy are covered according to criteria for durable medical equipment (DME).

- **Reconstructive Surgery**

  Reconstructive surgery, to restore anatomical function of the body from a loss due to illness or injury, when determined to be medically necessary by a participating PCP and prior authorized by the DHMP Medical Director, is covered.

- **Transplants**

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

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

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

  In network: $1,000 copay per admission

  Out-of-network: Not covered

Summary of Benefits

The chart included in this section provides you with a quick reference to the benefits available to you, your copayments, and any benefit limitations or maximums. The Summary of Benefits also describes any special exclusions or limitations that relate to a particular benefit. If you have further questions, consult the more detailed description of benefits and exclusions in Section 7 ~ Benefits/Coverage and Chapter 4 ~ General Exclusions, or call Member Services at 303-602-2100 or 800-700-8140.

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

8.1 Non-Network Providers

Services provided by a hospital, pharmacy or other facility or by a physician, dentist, or other provider not participating in the DHMP Medical Care or the Cofinity networks are not covered unless:

- Provided under prior written referral by a participating PCP and prior authorized by the DHMP Medical Management department or
- Provided in an Emergency or urgent circumstance subject to the conditions described in Section 1 – Schedule of Benefits, and notification is made to the DHMP Medical Management department as soon as reasonably possible, preferably within 48 hours.

8.2 General Exclusions

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

- **Abortion**: Abortions past the 15th week, except when medically necessary.
- **Adaptive Equipment/Corrective Appliances**: Artificial aids; adaptation to telephone for the deaf; augmentative communication device; replacement of artificial eyes if lost, stolen or damaged; reading aids, vision enhancement devices; cochlear implants; penile implants; wheelchair ramps; home remodeling or installation of bathroom equipment; prosthetic devices (except for artificial limbs and breast prostheses); orthotics or braces for sports activities; braces for chronic conditions present for 3 months or longer (except braces for scoliosis); and experimental braces.
- **Ambulance Services**: Ambulance service for non-emergency care or transportation except as requested by DHMP.
- **Artificial Hair**: Wigs, artificial hairpieces, hair transplants or implants, even if there is a medical reason for hair loss.
- **Care Not Medically Necessary**: Any care not deemed medically necessary by a DHMP PCP, specialist, or the DHMP Medical Director.
- **Comfort and Convenience Items**: Personal comfort or convenience items or services obtained or rendered in or out of a hospital or other facility, such as television, telephone, guest meals, articles for personal hygiene, and any other similar incidental services and supplies.
- **Cosmetic and Reconstructive Surgery**: Elective cosmetic and reconstructive surgeries or procedures that are only performed to improve or preserve physical appearance.
- **Criminal Exclusions**: A medical treatment for accidental bodily injury or sickness resulting from or occurring during the member's commission of a crime, except for a crime defined under 18-18-102(5) C.R.S.
- **Dental Services**: Dental services; dental ancillary services; occlusal splints; overbite or underbite; osteotomies; TMJ (except as a result of trauma or fracture); hard or soft tissue surgery; maxillary, mandibular or other orthogenic conditions unless certified by a participating primary care

practitioner (PCP) as medically necessary as a result of trauma. See exceptions in Section 7 - Benefits/Coverage, Oral/Dental Surgery.

- **Disability/Insurance Physicals**: Coverage for physicals to determine or evaluate a member's health for enrollment in another insurance is excluded from coverage.
- **Durable Medical Equipment**: Rental or purchase of durable medical equipment except if medically necessary and prior authorized by the DHMP Medical Management Department. Humidifiers, air conditioners, exercise equipment, whirlpools, health spa or club are excluded whether or not prescribed by a physician. You are responsible for the entire cost of lost, stolen or damaged equipment (other than normal wear and tear).
- **Enzyme Infusions**: Therapies for chronic metabolic disorders.
- **Employment Exams**: Physical examinations for purposes of employment or employment-required annual examinations (e.g., D.O.T. exams) are excluded from coverage.
- **Excluded drugs and drug classes for the prescription drug benefit**: Anti-wrinkle agents, cosmetic hair removal products, dietary supplements (some are covered as consumable medical expenses), hair growth stimulants, immunization agents, blood or blood plasma, infertility medications, pigmenting/depigmenting agents, [nicotine-containing and OTC smoking deterrents (exception: some smoking cessation medications may be covered while participating in a DHMP class)], therapeutic devices/appliances (except certain diabetic testing supplies), charges for the administration/injection of any drug, prescription vitamins (except fluoride, folic acid, prenatal, vitamin B-12 and vitamin D), Over-the-counter (OTC) medications (except insulin and blood glucose testing supplies)..
- **Experimental Procedures and Drugs**: All experimental procedures and drugs as defined by the DHMP Medical Director. Drugs must be FDA approved to be considered non-experimental.
- **Extended Care**: Sanitarium, custodial or respite care (except as provided under Hospice Services), maintenance care, chronic care and private duty nursing.
- **Family Planning and Infertility**: Reversal of voluntarily induced infertility (sterilization); sex change operations; procedures considered to be experimental; in vitro fertilization; the Gamete Intrafallopian Transfer (GIFT); surrogate parents; drug therapy for infertility and the cost of services related to each of these procedures; the cost related to donor sperm (collection, preparation, storage etc.) for artificial insemination for members not currently receiving active treatment for infertility utilizing this assisted reproductive technology.
- **Formulary**: The Denver Health Medical Plan Formulary assists providers in selecting clinically appropriate and cost-effective medications for the Denver Health Medical Plan members. Notice of any additions to this list will be given in provider and member newsletters and our web site at www.denverhealthmedicalplan.com.
- **Governmental Facilities**: Services or items for which payment is made by or available from the federal or any state government or agency or subdivision of these entities; services or items for which a DHMP member has no legal obligation to pay.
- **Laboratory and Pathology Services**: Paternity testing; genetic testing to determine risk for developing cancer or chronic diseases; blood typing in the absence of transfusion.
- **Learning and Behavior Problems**: Special education, counseling, therapy or care for learning disabilities or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance.
- **Maternity Care**: Home deliveries; scheduled, non-medically necessary Cesarean sections; newborns of a dependent unless the newborn (grandchild) is the legal responsibility of the member; proof of court-ordered legal guardianship is required.
- **Medical Food**: Food products for cystic fibrosis or lactose or soy intolerance.
- **Neurostimulators**: Replacements or repairs, including batteries.
- **Obesity**: Commercial weight loss programs or exercise programs.
- **Ophthalmology**: Any costs for routine exams, eyewear, and for refractive LASIK surgery.
- **Optometric Vision Therapy/Treatment**: Individualized treatment regimen prescribed in order to provide medically necessary treatment for diagnosed visual dysfunctions,

prevent the development of visual problems, or enhance visual performance to meet defined needs of the patient. Optometric vision therapy includes visual conditions such as strabismus, amblyopia, accommodative dysfunctions, ocular motor dysfunctions, visual motor disorders, and visual perceptual (visual information processing) disorders.

- **Other Providers**: Services provided by acupuncturists, massage therapists, faith healers, palm readers, physiologists, naturopaths, reflexologists, rolfers, iridologists, or other alternative health practitioners.
- **Outpatient Psychiatric/Mental Health**: Psychological testing required by a third party; educational or occupational testing or counseling; vocational or religious counseling; developmental disorders such as reading, arithmetic, language or articulation disorders; IQ testing.
- **Over-the-Counter Drugs**: Over-the-counter drugs, nutritional supplements or diets, and over-the-counter medical supplies (except insulin and diabetic testing supplies). Vitamins, minerals or special diets, even if prescribed by a physician (except medical food for children with inherited enzymatic disorders) with the exception of the non over-the-counter prescriptive items such as electrolytes, certain vitamins and minerals which are listed in the Denver Health Medical Plan formulary.
- **Plastic Surgery**: Plastic surgery for cosmetic purposes; removal of tattoos and scars; chemical peels or skin abrasion for acne.
- **Private Duty Nurses**: Services of private duty nurses.
- **Residential Treatment**: Residential treatment facilities provide 24-hour care with counseling, therapy and trained staff.
- **Transplants**: Organ transplants except for: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome and lymphoma; donor-related expenses for donors who are members of DHMP who are donating to an individual who is not a DHMP member.
- **Vocational Rehabilitation**: Vocational rehabilitation, services related to screening exam or immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any other non-preventive purpose.
- **Work-Related Injury or Illness**: Charges for services and supplies (including Return to Work exams) resulting from a work-related illness or injury, including expenses resulting from occupational illnesses or accidents covered under workers' compensation, employers' liability, municipal, state or federal law or occupational disease laws except for members who are not required to maintain or be covered by workers' compensation insurance as defined by Colorado workers' compensation laws.

9 Member Payment Responsibility

9.1 About Your Medical Benefits

All services covered by DHMP must satisfy certain basic requirements. The services you seek must be medically necessary; you must use Denver Medical Care Network providers; the services cannot exceed benefit maximums; and the services must be appropriate for the illness or injury. These requirements are commonly included in health benefit plans but are often not well understood or are simply overlooked. By communicating with your PCP and allowing your PCP to manage your care, these requirements will be met and will help to ensure that you receive medically necessary covered services.

9.2 Copayments

A copayment (or copay) is a predetermined amount, sometimes stated as a percentage and sometimes stated as a fixed dollar amount, that you are required to pay to receive a covered service. Copayments are paid directly by you to the provider. For applicable copayments, see the Summary of Benefits at the beginning of this chapter. You will be responsible for all expenses incurred for non-covered services.

9.3 Benefit Maximums

Benefit maximums are the limits set by DHMP on the number of visits per calendar year, number of inpatient days per calendar year, or on the specific dollars paid by DHMP per calendar year.

10 Claims Procedure (How to File a Claim)

10.1 How to File a Claim

For Medical Service

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

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

There are situations in which you may need to file a claim for care you receive. If you receive emergency or urgent care from a provider outside of the Denver Medical Care Network, you may be asked to pay the entire bill or a portion of the bill at the time of service. Eye wear and hearing aids may be purchased from any eye wear or hearing aid supplier. You may be required to pay the entire amount to the provider at the time of service. DHMP will reimburse you up to the limits noted in Section 7 - Summary of Benefits. If you are required to pay at the time of service, mail your receipt, including your name, home mailing address and member ID number to the following address:

Denver Health Medical Plan, Inc.
Attention: Claims Department
P.O. Box 40637
Denver, CO 80204-0637

To be reimbursed for eye wear and orthotics, please use the reimbursement form, Attachment D, at the end of this handbook. DHMP will mail a reimbursement check to the subscriber's home address, in the amount up to the benefit maximum. Claims submitted to DHMP later than 120 days after the date of service may be denied due to late filing.

For Pharmacy Service

Present your DHMP identification card at any MedImpact network pharmacy when you have your prescriptions filled. You are responsible for paying the pharmacy copayment. If you are out of the Denver Medical Care Network Area and cannot locate a network pharmacy, please call the Member Services Department at 303-602-2100 or 800-700-8140 for information on how to get your prescription filled. If you pay the full cost for an eligible prescription medication, please mail your pharmacy receipt, along with your name, mailing address and member ID number, to the following address:

Denver Health Medical Plan, Inc.
Attention: Pharmacy Department
777 Bannock Street, Mail Code 6000
Denver, CO 80204

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

10.2 Claims Investigation

If you have questions or concerns about how a claim is settled, please call the Member Services Department at 303-602-2100 or 800-700-8140, TTY/TDD users should call 303-602-2129 or toll free at 1-866-538-5288. If you disagree with the manner in which DHMP has settled a claim, or if you disagree with a denial of a claim payment, you may file a written or verbal grievance. See Attachment A at the back of the handbook for a copy of this form. You may also obtain a grievance form, or if you wish, give DHMP the details of your disagreement over the telephone by calling 303-602-2100 or 800-700-8140. You may also write to:

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

If you are appealing a claim that was denied due to lack of medical necessity or prior authorization, denial of prior authorization, or experimental status, please see Chapter 7 (Grievance and Appeal Process).

10.3 Claims Fraud

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for

the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or payment from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

10.4 Coordination Of Benefits

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and chose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits each group health plan to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first. Any plan that does not contain your state's coordination of benefits rules will always be primary.

When This Plan Is Primary

If you are a family member covered under another plan in addition to this one, we will be primary when:

Your Own Expense

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expense

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- Your Child's Expense
- The claim is for the health care expenses of a child covered by this plan and
- Your birthday is earlier in the year than your spouse's. This is known as the "birthday rule"; or
- You have informed us of a court decree that makes you responsible for the child health care expenses; or
- There is no court decree but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part of all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayment and deductible.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we should have paid if we had been primary. We will credit any savings to a "benefit reserve" that can be used to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care, but allows expenses we do not cover, we will pay for those items as long as you have a balance in your benefit reserve.

We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Coordination of benefits applies when you have automobile insurance with medical payment coverage. Medical payment coverage is always primary to this Plan when you are injured in an automobile accident. Medical payment coverage can also be used to pay any coinsurance or copayment amounts that you may be required to pay under this Plan.

10.5 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:

- The Denver Health Medical Plan, Inc. ("DHMP") may collect paid benefits directly from the liable party, the liable party's insurance company, and from any other person, business, or insurance company obligated to provide benefits or payments to you including your own insurance company if you have medical payment, uninsured, underinsured, or other coverage.
- You will tell DHMP, within 30 days of your becoming injured or ill:
- If another party caused your injury or illness.
- The names of the liable party and that party's insurance company.
- The name of your own insurance company if you have coverage for your injury or illness.
- The name of any lawyer that you hired to help you collect your claim from a liable party.
- You or your lawyer will notify the liable party's insurance company, and your own insurance company, that:

The DHMP is paying your medical bills.

The insurance company must contact DHMP to discuss payment to DHMP.

The insurance company must pay DHMP before it pays you or your lawyer.

- Neither you nor your lawyer will collect any money from an insurance company until after DHMP is paid in full. This applies even if the insurance money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.
- If an insurance company pays you or your lawyer and not DHMP, you or your lawyer will pay the money over to DHMP up to the amount of benefits paid out. DHMP will not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- DHMP will have an automatic subrogation lien, and direct right of reimbursement, against any insurance money that is owed to you by an insurance company, or that has been paid to your lawyer. DHMP may notify other parties of its lien and direct right of reimbursement.
- DHMP may give an insurance company and your lawyer any DHMP records necessary for collection. If asked, you agree to sign a release allowing DHMP records to be provided to an insurance company and your lawyer. If asked, you agree to sign any other papers that will help DHMP collect.
- You and your lawyer will give DHMP any information requested about your claim against the liable party.
- You and your lawyer will notify DHMP of any dealings with, or lawsuits against, the liable party.
- You and your lawyer will not do anything to hurt the ability of DHMP to collect paid benefits from the liable party or an insurance company.
- You will owe DHMP any money that DHMP is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMP any attorney's fees and costs that DHMP must pay in order to collect this money from you. If you or your lawyer do not help, or interfere with, DHMP in collecting paid benefits, then DHMP may contact the State of Colorado and request that you be disenrolled for cause from DHMP and placed in Medicaid fee-for-service.
- DHMP will not pay any medical bills that should have been paid by another party or insurance company.
- If you have questions, please call our Member Services Department at 303-602-2100.

10.6 Disclosure of Health and Billing Information to Third-Parties

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

10.7 Venue

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

11 General Policy Provisions/HIPAA

Effective April 14, 2003

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

At Denver Health Medical Plan, Inc. (DHMP), we respect the privacy of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

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

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

We are required to follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will mail a copy of the new notice to all subscribers covered by DHMP at that time.

How We Use or Share Information

- Federal law allows us to use or share protected health information for the purposes of treatment, payment, and health care operations without your authorization. The following are ways we may use or share information about you:
- We may use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor.
- We may use or share your information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- We may share your existing drug profile with another prescribing provider in order to reduce drug interactons.
- We may use or share information for such health care operations as conducting quality assessment and improvement activities; care coordination or case management; and underwriting or premium rating.
- We may share your information with others who help us conduct our business operations. For example, consultants who provide legal, actuarial, or auditing services, or collection activities. We will not share your information with these outside groups unless they agree to keep it protected.
- We may share information with insurance companies and others who are obligated to pay your medical bills
- We may use or share your information for certain types of public health or disaster relief efforts.
- We may use or share your information to send you a reminder if you have an appointment with your doctor.
- We may use or share your information to give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we might send you information about smoking cessation or weight loss programs.
- We may use or share your information with the plan sponsor as necessary to carry out administrative functions of the plan. We will not share detailed health information with your health benefit plan sponsor.

There are also state and federal laws that may require DHMP to use or share your health information without your authorization as follows:

- We may provide information to a family member, friend, or other person, for the purpose of helping with your health care or with payment for your health care, if you are in a medical emergency and you cannot give your agreement to DHMP to do this.
- We may provide information to a personal representative designated by you or by law.
- We may report information to state and federal agencies that regulate us such as the US Department of Health and Human Services and the Colorado Division of Insurance, the Colorado Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.

- We may report information to public health agencies if we believe there is a serious health or safety threat.
- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions).
- We may provide information to a court or administrative agency (for example, pursuant to a court order or search warrant).
- We may report information for law enforcement purposes.
- We may report information to a government authority regarding child abuse, neglect, or domestic violence.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes, or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security, and intelligence activities, and the protective services for the President and others.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.

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

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

What Are Your Rights

The following are your rights with respect to your health information. If you would like to exercise the following rights, please contact the DHMP Member Services Department by telephone at 303-602-2100 or 800-700-8140, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m., or by U.S. mail at 777 Bannock Street, Mail Code 6000, Denver, CO 80204.

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

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

You have the right to ask to receive confidential communications of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by telephone) or to an alternative address. We will accommodate a reasonable request if the normal method or disclosure could endanger you and you state that in your request. Any such request must be made in writing to the Member Services Department.

You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A "designated record set" is a group of records that may include enrollment, payment, claims adjudication, and case or Medical Management department records.

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

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

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

right to have the denial reviewed.

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

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

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

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

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

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

You have a right to receive a copy of this notice upon request at any time. Requests for a copy of this notice should be directed to the Member Services Department.

Questions or Complaints

If you have any questions about this notice or about how we use or share information, please contact the DHMP Member Services Department at 303-602-2100 or 800-700-8140, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

You may also contact us by U.S. mail at 777 Bannock Street, Mail Code 6000, Denver, CO 80204.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the DHMP Member Services Department at 303-602-2100 or 800-700-8140, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

12 Termination/Nonrenewal/Continuation

12.1 Continuation of Coverage Under Federal Law

This section provides general information about continuation of coverage under federal law known as COBRA (which stands for "Consolidated Omnibus Budget Reconciliation Act"). Under this law, you or your dependents may be able to continue as members of DHMP even though you or your dependents no longer qualify for coverage as an employee or eligible dependent. Your benefits will not change if you continue with DHMP under COBRA. Certain "qualifying events" may trigger eligibility for continuation of coverage under COBRA. They include:

Termination of Employment

If your employment terminates for any reason except gross misconduct, you may elect continuation coverage for yourself and your covered dependents.

Reduction in Hours Worked (Full-Time to Part-Time)

If your work hours are reduced, and as a result you become ineligible for employer paid health insurance, you may elect continuation coverage for yourself and your covered dependents.

Divorce, Legal Separation, or Death

If you and your spouse divorce or legally separate or if you should die, your covered spouse and your other covered dependents may elect continuation coverage for themselves.

Medicare Eligibility

If you become eligible for Medicare, and your eligibility results in the loss of coverage for your covered dependants, your covered spouse (if not entitled to Medicare) and other covered dependents may elect continuation coverage. Additionally, DHMP may be selected by you as a secondary payer under certain circumstances.

Loss of Eligibility

If your covered dependent child becomes ineligible for coverage under DHMP due to your employer's eligibility requirements, your covered dependent child may elect continuation coverage.

12.2 Notification Requirement

The table below outlines the responsibility of the employer, employee and DHMP in the event that an employee loses coverage.

Type	Employee	Employer	DHMP
Event		Notify employee of rights within 10 days of qualifying event	
Election	Notify employer within 60 days of receipt of employer notification of intent to continue coverage	Notify DHMP of employee's intent to continue coverage	DHMP will provide coverage to employee subject to conditions as set by law
Premium payment	Pay premium to employer within 45 days after electing coverage -Premium charge is 100% of total premium (from date of qualifying event) plus 2% administrative charge (disabled - 150% of premium)	Forward premiums to DHMP by the 1st of each covered month of benefits	DHMP will provide coverage to employee subject to conditions as set by law

12.3
Maximum Period Of Continuation Coverage

The maximum period of continuation coverage is dependent on the qualifying event. The table below briefly describes the maximum period of continuation coverage for each category of qualifying event.

Qualifying Event	Continuation Period	Qualified Beneficiaries
Termination of employment (except for gross misconduct) or reduction in work hours of the employer	18 months	Employee, covered spouse and covered dependents
Death of employee	36 months	Covered spouse, covered dependents
Divorce or legal separation of the employee from employee's spouse	36 months	Covered spouse, covered dependents
Medicare: employee becomes eligible for Medicare and that eligibility results in the loss of coverage for your covered dependents	36 months	Covered spouse, covered dependents
Non-dependent child: dependent child ceases to be a dependent child under the requirements of the DHMP	36 months	Covered dependent child
Social Security Administration determines that a qualified beneficiary was disabled at the time of the qualifying event or within the 60-day election period after the qualifying event (except when termination or reduction of working hours is due to gross misconduct).	29 months	Disabled beneficiary

Newborn or Adopted Children of Qualified Beneficiaries

Only you, by reason of having been an employee, and your child born or adopted during the continuation period, have an independent right to continue or change a coverage election during the continuation period. All other dependents are obligated to continue the coverage option chosen by the employee. However, you must enroll your new child (ren) as a dependent within 31 days of birth, adoption, and legal guardianship or new spouse as a result of marriage, in order to have this added protection. Any increase in premium due to this change must be paid during the period for which the coverage is in effect.

More Than One Qualifying Event

If an individual experiences more than one qualifying event, all qualified beneficiaries under the second qualifying event will be entitled to 36 months of continuation coverage, computed from the date of the first qualifying event.

Termination of Continuation Coverage

Continuation coverage will terminate, prior to the maximum period stated above, if:

- You or your dependent fail to make a premium payment within 30 days after the date it is due.
- You or your dependent become covered as an employee or otherwise under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition.
- You or your dependent become entitled to Medicare benefits.
- Your former employer no longer maintains any group health plan.

State Continuation Coverage

If the COBRA coverage described above does not apply (e.g. because you were terminated for gross misconduct), you and your eligible dependents may still be eligible for continuation coverage under state law if:

- your coverage was terminated for reasons other than discontinuation of a group plan in its entirety;

- you have been continuously covered under the group plan for at least six (6) months immediately prior to the termination of your coverage; and
- you are not covered by Medicare or Medicaid.

Continuation coverage under state law is for a period of 18 months from the date of termination. The coverage will end before the exhaustion of the 18-month period if:

- you become eligible for other group coverage; if the new coverage excludes a condition covered by the continuation coverage, you may be covered by DHMP for that condition only for 18 months or until the new plan covers the condition, whichever occurs first.
- you fail to pay premiums when due.

Your employer will notify you of the right to continuation coverage under state law within 10 days of termination. You must notify your employer of your election of continuation coverage within 30 days after termination of employment.

12.4 Conversion Coverage

Eligibility for Conversion Coverage

Once continuation coverage has been exhausted (or if you are not eligible for continuation coverage), you and your covered dependents may obtain conversion coverage if the following conditions are met:

a) you have been continuously covered under the group plan for at least three months;

b) you make written application for conversion coverage to DHMP and pay the first month's premium to DHMP within 31 days after your continuation coverage expires;

c) you and your dependents are not covered by Medicare at the time of application; and

d) you and your dependents are not covered by or eligible for similar benefits under another group or individual plan, such that the other coverage, together with the converted policy, would result in over-insurance according to DHMP's standards.

Conversion coverage is individual, not group coverage. Conversion policies will be issued without any evidence of insurability. A basic and a standard plan are available. Call Member Services at 303-602-2100 or 1 800-700-8140 to find out more about conversion plans.

Notice of Conversion Right

Your employer will give you written notice of your right to convert to an individual conversion policy before the expiration of your continuation coverage. If you do not receive timely notice, you will have 15 days from the date of the notice received to elect conversion coverage.

Premium Payment

Premiums are determined by DHMP in accordance with its table of premium rates applicable to age and enrollment status (single vs. family, etc.). Premiums are paid directly to DHMP, with the first month's premium paid within 31 days after your coverage under the group plan expires.

When Conversion Coverage Becomes Effective

Conversion coverage becomes effective on the day following the expiration of your coverage under the group plan.

When Conversion Coverage Ends

Conversion coverage ends when:

a) you and your dependents are covered for similar benefits under another plan (individual or group); or

b) you and your dependents are eligible for similar benefits under any group plan;

c) the end of the last month for which premium is paid; or

d) you and your covered dependents voluntarily terminate your coverage; or

e) you or your covered spouse are covered by Medicare. The spouse not covered by Medicare and your other covered dependents may continue under the conversion policy.

13 Appeals and Complaints

13.1 The Difference Between Grievance and Appeal

As a member of DHMP, you have the right to voice Grievances. A Grievance is a written or oral request that the Plan investigate the quality of care you receive, the failure of a provider or the Plan to accommodate your needs, an unpleasant experience or any other service issue, including but not limited to the determinations of covered benefits. An Appeal is a written or oral request that the Plan review an adverse decision about requested medical service, care or treatment, e.g., the Plan's decision to deny prior authorization for a test, or to deny a particular type of treatment.

13.2 How to File a Grievance

You may file a Grievance by writing or calling the Grievance and Appeal Department at 303-602-2261 or the Member Services Department at 800-700-8140, TTY/TDD users should call 303-602-2129 or toll free at 1-866-538-5288 or you can put your Grievance in writing by completing **Attachment A at the end of your Member Handbook**. If you are unable to make the Grievance yourself, you may assign a person to act on your behalf, by completing the Designated Personal Representative (DPR) form. (**Please see Attachment C in your handbook**) Please mail your Grievance to the following address:

DHMP Complaint Coordinator
777 Bannock St., MC 6000
Denver, CO 80204-4507

The Grievance team will conduct an investigation and attempt to resolve the issue. You will be contacted regarding the resolution of your Grievance by letter within 20 business days of receipt of the Grievance. The letter will explain how your grievance was resolved. You have the right to contact the Colorado Division of Insurance if your concerns are not satisfactorily resolved by DHMP.

13.3 How to File an Appeal

If you have received a letter stating that the requested service, care or treatment is denied the decision is called an adverse determination and is subject to the Appeal process. Many adverse determinations involve the question of whether a requested service, care or treatment is medically necessary. Sometimes the question is whether the requested treatment is experimental or a covered benefit.

Your provider can start the Appeal review process by requesting a peer-to-peer conversation about the adverse determination by calling the DHMP Medical Management Department at 303-602-2140. In peer-to-peer conversation, your provider may talk with the DHMP reviewer who made the adverse determination. The conversation should occur within five calendar days of the request. If your provider wants to Appeal on your behalf please submit a copy of the Designated Personal Representative form signed by you and your provider. **Please use Attachment C at the end of this handbook.**

An Appeal is a written request from you to DHMP that your denied request for service, care or treatment be further reviewed. In conducting Appeals, DHMP follows the procedures mandated by the Colorado Division of Insurance. There are two levels of appeals. **You may use Attachment B, at the end of this handbook**, to submit a written request for an Appeal. An Appeal may be requested instead of a peer-to-peer conversation or following peer-to-peer conversation if the decision is once again adverse. The Appeal request must be received by DHMP within 180 calendar days after the date you received notice of the initial denial.

First Level Appeal Reviews

First level Appeal reviews are evaluated by a physician who consults with an appropriate clinical peer or peers who was not previously involved in the initial adverse determination. The physician and clinical peer(s) shall not have been involved in the initial adverse determination.

In conducting a review the reviewer or reviewers will take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination. You will be notified of the decision in writing within 30 calendar days following the request for an appeal review. The notice letter will tell you the following: who performed the Appeal review, the reviewer's understanding of the request, the reviewer's decision in clear terms, the clinical rationale for the decision, any Handbook provision that applies, the guideline, criteria or other documents relied upon, the way to obtain a copy of any applicable guideline or criteria used, and how to file a voluntary second level Appeal review and external Appeal review.

Voluntary Second Level Appeal Reviews

If you are not satisfied with the first level Appeal review, you may request a second level review. Your request for a second level Appeal review must be in writing and filed within 30 calendar days of receipt of an adverse first level review decision. You can put your Voluntary Second Level Appeal in writing by completing Attachment B at the end of this Member Handbook. At the second level, your request for service, care or treatment

will be reviewed by a health care professional who was not involved in the previous denials and who does not have a direct financial interest in the Appeal or the outcome of the review.

The health care professional will have appropriate expertise in the type of care being reviewed. A review will be scheduled with the DHMP appeals Committee and held within 60 calendar days of receiving the request for a second level review. You will be notified in writing at least 20 calendar days in advance of the review date.

You may request a copy of the materials DHMP intends to present at the review; you must submit your request at least five days before the review. DHMP may also request a copy of all materials you intend to present at the review. You may present your case in person, in writing, through a representative, or by teleconference call and be assisted or represented by a person of your choice, including an attorney. You may ask questions of any DHMP representative prior to the hearing and the reviewer at the hearing; submit supporting material both before and at the review meeting. DHMP will make an audio or video recording of the review unless neither you nor DHMP wants the recording made. All comments, documents, records and other information about the request will be considered. The reviewer will send you a decision letter within seven calendar days of completing the review. The letter will include the name, title, and qualifying credentials of the reviewer; a statement of the reviewer's understanding of the nature of the Appeal review and all pertinent facts; a clear statement of the decision; the rationale for the reviewer's decision; the guideline, criteria or other documents relied upon; how to request a copy of all relevant documents mentioned above; and if the decision is adverse, how you can request an external review of your Appeal.

External Appeal Reviews

External review is available only for adverse decisions in the Appeal process where you have gone through at least one level of Appeal review. You or an authorized representative must send a written request for an external review to Member Services within 60 calendar days after you receive the result of your first or second level Appeal. External review is provided at no cost to you and is arranged by the Colorado Division of Insurance. The Division will assign an independent external review agency to perform a thorough review of your Appeal. You will receive a decision from the external review agency within 30 calendar days of its receipt of your request. Expedited external reviews are available if necessary.

Expedited Appeal Reviews

If the time frame of the standard review procedures set forth above, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or for the persons, with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently, you may request an expedited review. Expedited Appeal reviews can also be requested if in the opinion of a physician with knowledge of the covered person's medical condition, would subject their covered person to severe pain that cannot be adequately managed without the health service, care or treatment that is subject of the request. A decision will be made and you and your provider will be notified as quickly as your medical condition requires, but not more than 72 hours after the review is started. Initial notification will be made by telephone or sent by facsimile and, written confirmation sent within two working days of notification, if the initial notification was by telephone. Expedited Appeal reviews request can be made orally or in writing.

13.4 The Division of Insurance

If you have concerns that are not satisfactorily resolved by DHMP, you have the right to contact the Colorado Division of Insurance. Write to:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202

13.5 As a Member of the Denver Health Medical Plan, Inc.

As a member in the Denver Health Medical Plan, Inc., you are entitled to certain rights under federal law.

Denver Health Medical Plan, Inc. Records

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

Confidentiality of Member Medical Records

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

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

To make a request, call Member Services at 303-602-2100 or 800-700-8140. Members also have the right to inspect and obtain copies of their medical records maintained by Denver Medical Care Network providers. Please contact the individual provider for more details.

Notice of Privacy Practices

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

The Denver Health Medical Plan Notice of Privacy Practices has been included at the end of this Member handbook for your review. A new notice will be provided of any material change in our practices. You may, at any time, obtain a copy of the notice by contacting Member Services at 303-602-2100 or by calling 800-700-8140.

Administration of Covered Benefits

Under federal law, individuals responsible for the operation of DHMP must perform their duties in a careful and conscientious manner, and with the interest of all members taken into consideration. DHMP and/or its agents will professionally and consistently strive to administer the Plan in accordance with this handbook, to the specific definitions of terms used (see Chapter 9 – Definitions of Terms) and applicable state and federal laws. DHMP will assist you in obtaining the benefits for which you are eligible. No one, including your employer, a union or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under this plan or exercising your rights under law.

Agreement to the Terms in Handbook

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

13.6 Your Rights and Responsibilities at Denver Health

Know what your rights and responsibilities are. Direct any questions, comments or problems to the DHMP Member Services Department at 303-602-2100 or 800-700-8140.

Member's Rights

- To be treated with courtesy, respect, and recognition of your dignity and right to privacy.
- To receive equal and fair treatment, without regard to race, religion, color, creed, national origin, age, sex, sexual preference, political party, disabillity, or participation in a publicly financed program.
- To know the names and titles of the doctors, nurses, and other persons who provice care or services for the member.
- To be told what your condition is and the recommended treatment, how your condition is expected to change, and what follow-up is needed.
- To participate with your provider in making decisions about your health care.
- To request or refuse treatment to the extent of the law and to know what the outcomes may be.
- To choose or change your PCP within the network of providers, to contact your PCP whenever a health problem is of concern to you and arrange for a second opinion if desired.
- To expect that your medical records and anything that you say to your provider will be treated confidentially and will not be released without your consent, except as required or allowed by law.

- To receive quality care and be informed of the DHMP Quality Improvement program.
- To receive information about DHMP, its services, its practitioners and providers and members' rights and responsibilities, as well as prompt notification of termination or other changes in benefits, services or the Denver Medical Care Network.
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To express your opinion about DHMP or its providers to legislative bodies or the media without fear of losing health benefits.
- To receive an explanation of all consent forms or other papers DHMP or its providers ask you to sign; refuse to sign these forms until you understand them; refuse treatment and to understand the consequences of doing so; refuse to participate in research projects; cross out any part of a consent form that you do not want applied to your care; or to change your mind before undergoing a procedure for which you have already given consent.
- To instruct your providers about your wishes related to advance directives (such issues as durable power of attorney, living will or organ donation).
- To receive care at any time, 24 hours a day, 7 days a week, for emergency conditions and care within 48 hours for urgent conditions.
- To have interpreter services if you need them when getting your health care.
- To change enrollment during the times when rules and regulations allow you to make this choice.
- To have referral options that are not restricted to less than all providers in the network that are qualified to provide covered specialty services; applicable copays apply.
- To expect that referrals approved by the plan cannot be changed after Prior authorization or retrospectively denied except for fraud or abuse.
- Receive a standing referral, from a PCP to see a DHMP network specialty treatment center, for an illness or injury that requires ongoing care.
- To make recommendations regarding DHMP's Members' Rights and Responsibilities' policies.
- Complain about or appeal a decision concerning the Managed Care organization or the care provided and receive a reply according to the grievance/appeal process.

Member's Rights for Pregnancy and Special Needs:

- Receive family planning services from any licensed physician or clinic in the DHMP network.
- To go to any participating OB/GYN in the Denver Medical Care Network without getting a referral from your PCP.
- To see your current non-network provider for prenatal care, until after delivery of the baby if you become a member of DHMP during your second or third trimester. This is dependent upon the non-network provider agreeing to accept DHMP's arrangements.
- To continue to see your non-network doctor(s) or provider(s), when medically necessary, for up to 60 days after becoming a DHMP member. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)
- For DME, DHMP will authorize up to 75 days. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

Member's Responsibilities:

- To treat providers and their staff with courtesy, dignity and respect.
- To make and keep appointments, to be on time, call if you will be late or must cancel an appointment, and to have your DHMP identification card available at the time of service and pay for any charges for non-covered benefits.
- To report your symptoms and problems to your PCP and to ask questions, and take part in your health care.
- To learn about the procedure or treatment and to think about it before it is done.
- To think about the outcomes of refusing treatment that your PCP suggests.
- To get an authorization from your PCP before you see a Specialist.
- To follow plans and instructions for care that you have agreed upon with your provider.

- To provide, to the extent possible, correct and necessary information and records that DHMP and its providers need in order to provide care.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To state your complaints and concerns in a civil and appropriate way.
- Learn and know about plan benefits (which services are covered and non-covered) and to contact a DHMP Membership Services Representative with any questions.

Inform providers or a representative from DHMP when not pleased with care or service.

ADDITIONAL INFORMATION

Relationship between DHMP and Network Providers

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

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

Statement of Appropriate Care

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

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

If you feel that a DHMP representative or network provider has violated any of the above principles, you can contact the Member Services department at 303-602-2100 or 800-700-8140.

Conformity with State Law

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

Amendment or Termination of this Plan

This Plan can be modified by DHMP to change benefits only after notice to a subscribing group, unless the modification is required by a change in law.

Quality Improvement Program

DHMP continually strives to improve the quality of care and service to our members by ongoing monitoring of services. DHMP's Quality Improvement Program monitors and measures the level and quality of service and care, monitors compliance with certain preventive health measures, identifies opportunities to improve patient care, and resolves identified problems through appropriate intervention and education.

Some of the types of care that are measured and monitored on at least an annual basis include:

- Mammography and cervical cancer screening rates
- Childhood immunization rates
- Smoking cessation advice
- Treatment of asthma and diabetes
- Outpatient follow-up after an admission for a mental illness
- Referral turnaround time
- Member satisfaction with services and providers

Details of specific measurements can be found in the member newsletter from time to time. As a member of DHMP, you may request additional information regarding the Quality Improvement Program by calling Member Services at 303-602-2100.

14 Information on Policy and Rate Changes

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

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

15 Definitions

A Recommendation - means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

B Recommendation - means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

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

Adverse Determination: determination by the DHMP plan that request for benefit has been reviewed and based upon the information provided does not meet the plan requirement for medical necessity or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated.

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

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

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

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

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

Clinical Trial - an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

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

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

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

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

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

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

Denver Medical Care Network: The Denver Health and Hospital Authority and the Denver Health and Hospital Authority providers located on the Denver Health and Hospital Authority campus, Denver Health and Hospital Authority neighborhood health care facilities that are conveniently located throughout the Denver metropolitan area and a members-only medical clinic, located on the Denver Health and Hospital Authority campus.

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

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

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

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

Durable Medical Equipment: Medical equipment that can withstand repeated use is not disposable and is used to serve a medical purpose in the treatment of an active illness or injury. Durable medical equipment is owned or rented to facilitate treatment and/or rehabilitation.

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

Emergency Medical Condition: The sudden and unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, would place the person's health in serious jeopardy.

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

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

General Hospital: A health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding 24 hours to individuals requiring diagnosis and treatment for illness, injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic x-ray, and definitive medical treatment under an organized medical staff are provided within the institution. Treatment facilities for emergency and surgical services are provided either within the institution or by contractual agreement for those services with another licensed hospital. Services provided by contractual agreement are documented by a well-defined plan for the provision of contracted services, related to community needs. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, radiation therapy, and similar specialized treatment.

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

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder. Grievance: An oral or written statement by a provider, member or member's representative that expresses dissatisfaction with some aspect of DHMP service or administration.

Health Care Provider: Physician, practitioner, hospital, home health care agency, hospice or other specialized treatment facility that provides health care services. A health care provider can be either an individual or an organization.

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

(1) has policies established by a group of professional personnel associated with the agency or organization including policies to govern which services the agency will provide,

(2) maintains medical records of all patients, and

(3) is certified or accredited.

Hospice Care: An alternative way of caring for terminally ill individuals that stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the patient. Hospice

services include but are not necessarily limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

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

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

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

Medically Necessary (Medical Necessity): Appropriate and necessary services as determined by your PCP, specialist or the DHMP Medical Director, that are provided to a member according to accepted principles of good medical practice, for diagnosis or direct care and treatment of an illness or injury and are not provided only as a convenience.

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

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

Network Area: The counties of Denver, Arapahoe, Jefferson and Adams.

Network Provider: A health care provider who is contracted to be a provider in the Denver Medical Care Network.

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

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

Observation Stay: A hospitalization lasting 23 hours or less.

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

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

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

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

Primary Care Practitioner (PCP): The practitioner (physician, nurse practitioner or physician's assistant) that you choose from the Denver Medical Care Network to supervise, coordinate and provide initial and basic care to you. The PCP initiates referrals for specialist care and maintains continuity of patient care (usually a physician practicing internal medicine, family practice or pediatrics).

Prior authorization: authorization prior to receiving a specific service, treatment or care. Prior authorization must be requested by your primary care provider who needs to send the request along with medical necessity information.

Problems of Living: Stress-related conditions for which marital and couples counseling and family therapy are covered.

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

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

For Enrollment: any event that permits an individual to enroll outside open enrollment or initial eligibility periods (e.g., marriage, birth, adoption placement, divorce, legal separation, loss of dependent status).

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

Retirees: Subscribers who qualify for coverage under the Plan after retiring from an employer group.

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

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

(1) permanent and full-time facilities for ten or more resident patients;

(2) a full-time registered nurse or physician in charge of patient care;

(3) at least one registered nurse or licensed practical nurse on duty at all times;

(4) a daily medical record for each patient;

(5) transfer arrangements with a hospital;

(6) and a utilization review plan.

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

Standing Referral: Referral from PCP to a network specialist or specialty treatment center in the Denver Medical Care Network for illness or injury that requires ongoing care.

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

Subscriber: The employee whose employment is the basis for eligibility for enrollment in DHMP.

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

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

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

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

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ATTACHMENT A
Denver Health Medical Plan

Member Grievance Form

Member's Name _____Member's Date of Birth_____

Member's ID Number _____ Member's Medical Records #

Name of Member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

_____

_____

_____

Date of Incident _____

Contact Phone Number_____

Person(s) or Provider(s) involved _____

_____

Describe what happened _____

_____

_____

_____

_____

Signature of Member/DPR/Guardian _____
Date _____

Please send to: **Denver Health Medical Plan**
Attn: Complaints Coordinator
777 Bannock St., MC 6000
Denver, CO 80204-0606
Phone: 303-602-2261

Form No.: COM_MF_103-00
Creation/Rev Date 12/31/12

CONFIDENTIAL

ATTACHMENT B
Denver Health Medical Plan

Member Appeal Form

Member's Name _____Member's Date of Birth_____

Member's ID Number _____ Member's Medical Records #

Name of Member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

_____

_____

_____

Date of initial denial letter_____

What was denied? _____

Reason for the denial (as noted in the letter) _____

Describe any new information since the initial review of this matter_____

_____

_____

_____

_____

Signature of Member/DPR/Guardian _____

Date _____

Please send to: **Denver Health Medical Plan**
Attn: Complaints Coordinator
777 Bannock St., MC 6000
Denver, CO 80204-0606
Phone: 303-602-2261

** To request an appeal of a decision regarding an adverse determination, this form must be submitted within 180 calendar days.

** If your initial request was denied as a non covered benefit, you need to provide additional medical evidence from your provider explaining why benefit exclusion should not apply in this case.

CONFIDENTIAL

ATTACHMENT C
Denver Health Medical Plan
Designation of Personal Representative

I, _____ (PRINT name of client), name and appoint

_____ (PRINT name of representative), to serve as my Designated Personal Representative.

I understand that my Designated Personal Representative will have access to information about me that is created by or on behalf of the Denver Health Medical Plan, and that this information can include Protected Health Information. My Designated Personal Representative is to be provided information about me, on my behalf, in order to assist me as I request of him/her.

This designation of a personal representative is being made in order that the designated individual act on my behalf in:

____ All actions required of me in my relationship with the Denver Health Medical Plan; *or*

____ Actions required of me in relation to the following specific purpose (check one that applies):

❑ Grievance ❑ Appeal _____ ❑ Other (please specify) _____

I understand that my Designated Personal Representative may disclose my information to a third party, and that the State Department has no control over that additional disclosure and can not protect the information after it is provided to my Designated Personal Representative.

I understand that I may revoke this Designation at any time by writing to the address below, and that this Designation will not expire unless and until I actively revoke it.

I understand that my health care treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating a Designated Personal Representative.

I understand this executed form does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions or treatment or psychotherapy notes, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.

Client signature: _____ **Date:** _____
Parent or Legal Guardian may sign on behalf of minor child.
Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult – documentation is required.

Client Date of Birth: _____

State ID #, Client ID #, or Member ID #: _____ *Used for identity verification purposes only*

Designated Personal Representative signature: _____

Designated Personal Representative relationship to Client: _____

Designated Personal Representative phone number: _____

Return Completed Form To: **Denver Health Medical Plan Inc.**
Attn.: Complaints Coordinator
777 Bannock Street, MC6000
Denver, CO 80204
Phone: 303-602-2261 • Fax: 303-602-2094

ATTACHMENT D
Denver Health Medical Plan

Authorization to Disclose Protected Health Information

I _____ , authorize Denver Health Medical Plan, Inc. ("DHMP"), and its attorneys and agents to release medical billing, medical claims, and health information regarding DHMP Member:

Member's Full Legal Name: _____

Member's Plan I.D. number:_____ **Member's Date of Birth:** _____

to the following:

Facility/Office/Company/Person_____

Address _____

City _____ State

Zip Code_____

This disclosure is related to (check all that apply)

____ all claims with dates of service between _____ and _____

____ limited to claims with dates of service related to an accident/incident occurring on or about _____.

____ other records or limitations (please specify) _____

The purpose of this disclosure is to permit DHMP and its attorneys and agents to collect payment for my medical expenses from responsible third parties and/or to use such information in legal proceedings relating to payment for my medical care.

Other purpose (if applicable)_____

I understand by signing this form I have given my permission to release confidential medical and insurance billing information related to my medical claims, medical billing and medical care and treatment, which may include the following:

Diagnosis and/or treatment relating to mental health conditions, sexually transmitted diseases, and/or HIV/AIDS, unless restricted as follows _____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

I understand I have a right to revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one (1) year from the date of signature. DHMP may not condition payment, eligibility or receipt of benefits upon the signing of this form; however, the information requested may be necessary for the payment of my medical bills or the operations of DHMP in accordance with applicable law. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality laws (HIPAA).

A copy or facsimile of this authorization is as valid as the original. If I have questions about disclosure of my health information, I can contact DHMP Member Services at 303-602-2100.

Signature of Member or Legal Representative_____

Date of signature _____

Relationship of Legal Representative (Mother, Father, Guardian) _____

Please complete this form, sign, and fax to Denver Health Medical Plan, Inc. at 303-602-2094.

ATTACHMENT E
Denver Health Medical Plan, Inc. (CSA/DERP)

2013
Member Reimbursement Form (CSA/DERP/DPPA)

Member's Name: _____

Mailing Address:_____

Member's I.D. Number: _____

JENNY CRAIG:

_____ S9449 25% monthly program reimbursement up to $150/month

ORTHOTICS:

_____ L3000 $50.00
Maximum benefit per calendar year

HEARING AID:

_____ V5100 $1500.00 every 5 years, if 18 years of age or older

Please NOTE: All necessary receipts must be submitted with reimbursement request.

Mail Claims to: **Denver Health Medical Plan**
Attn: Claims Department
P.O. Box 262269
Plano, TX 75026

Form No.: COM_MF_107-00
Creation/Rev Date 12/31/12

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.com. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Denver Health Medical Plan, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.com.
The lifetime limit on the dollar value of benefits under Denver Health Medical Plan, Inc. no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Denver Health and Hospital Authority Employee Benefits at 303-602-7000.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Denver Health Medical Plan, Inc. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2012. For more information contact Denver Health and Hospital Authority Employee Benefits at 303-602-7000.

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

All Denver Health Medical Plan, Inc. enrollees have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 whenever an enrollee is confronted with a life- or limb-threatening emergency.

DENVER HEALTH
Medical Plan, Inc.

777 Bannock St., MC 6000
Denver, CO 80204
Member Services: 303-602-2100
www.denverhealthmedicalplan.com

Form No. COM_MKT_112-01
Created on 1/1/13

Member Handbook

WE TAKE YOUR
HEALTH
personally.

Career Services Authority (CSA)
and DERP Non-Medicare Primary
Denver Medical Care
Deductible HMO (DHMO)

2013

1 Summary of Benefits

Denver Health Medical Plan, Inc.
Career Service Authority and DERP Non Medicare
Denver Medical Care Deductible HMO (DHMO) - 2013 Summary of Benefits

	In Network	Out-of- Network
1. DEDUCTIBLE TYPE	Calendar year	N/A
2. DEDUCTIBLE **a) [Individual] [Single]** **b) [Family] [Non-single]**	a) $500 per year b) $1,500 per year • Member Copayments do not accumulate towards the Deductible. • All individual Deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual Deductible amount. • This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence deductible must be met prior to and in addition to the Annual Deductible.	N/A
3. OUT-OF-POCKET ANNUAL MAXIMUM **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $2,500 per year b) $5,000 per year c) Yes • The Out-of-Pocket Maximum includes the Annual Deductible. • All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount. • Member Copayments and Per Occurrence Deductibles do not accumulate towards the Out-of-Pocket Maximum.	N/A
4. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	N/A
5. COVERED PROVIDERS	Denver Health and Hospital Authority providers, Columbine Chiropractic, and Denver Health Medical Center. See provider directory for a complete list of current providers.	Not covered
6. WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED IN 5 ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes.	Not applicable

	In Network	Out-of- Network
6. MEDICAL OFFICE VISITS/ SERVICES **a) Primary Care Providers** **b) Specialists**	a. $25 Copayment per visit for Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. b. $50 Copayment per visit for Physician Office Visit (with a referral from Primary Physician). c. In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.	Not covered
7. PREVENTIVE CARE SERVICES **a) Children's** **b) Adult's**	a. No copayment (100% covered): b. No copayment (100% covered): $0 copay also includes all items on USPSTF preventive list Immunizations: No cost for injection only; if part of an office visit, applicable office visit copay will apply	Not covered
8. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care**	a. $25 Copayment per visit for In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. b. 20% coinsurance after Per Occurrence Deductible of $150 and Annual Deductible	Not covered

	In Network	Out-of- Network
9. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	If prescription filled at a Denver Health Pharmacy (30-day supply): Tier 1: $12 copay Tier 2: $40 copay for brand name drugs Tier 3: $50 copay for non-preferred drugs Denver Health Pharmacies or Pharmacy Delivery by Mail (90-day supply): Tier 1: $24 copay Tier 2: $80 copay for brand name drugs Tier 3: $100 copay for non-preferred drugs If prescription filled at a non-Denver Health Pharmacy (30-day supply): Tier 1: $20 copay Tier 2: $50 copay for brand name drugs Tier 3: $80 copay for non-preferred drugs (PA) If prescription filled at a non-Denver Health Pharmacy (90-day supply): Tier 1: $40 copay Tier 2: $100 copay for brand name drugs Tier 3: $160 copay for non-preferred drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
10. INPATIENT HOSPITAL	20% after: Per Occurrence Deductible of $150 and Annual Deductible have been met (with a referral from your Primary Physician).	Not covered
11. OUTPATIENT/AMBULATORY SURGERY	20% after: Per Occurrence Deductible of $75 and Annual Deductible have been met (with a referral from your Primary Physician).	Not covered
12. SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC	20% after Deductible has been met. Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, or Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Category.	Not covered
13. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services.**	a) 20% after Deductible has been met. b) $150 Copayment per service.	Not covered
14. EMERGENCY CARE	$300 Copayment per visit (waived if admitted).	$300 copay per visit (waived if admitted)
15. AMBULANCE	20% after Deductible has been met.	20% after Deductible has been met.

	In Network	Out-of- Network
16. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$75 Copayment per visit. > In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.	$75 Copayment per visit. > In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.
17. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS **a) Inpatient care** **b) Outpatient care**	 a) 20% after Deductible has been met. b) $50 Copayment per visit.	Not covered
18. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	 a) 20% after Deductible has been met. b) $50 Copayment per visit.	Not covered
19. ALCOHOL & SUBSTANCE ABUSE **(If not covered under #17 above as a mental disorder)**	Inpatient care: 20% after Deductible has been met. Outpatient care: $50 Copayment per visit.	Not covered
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$25 Copayment per visit. Benefits are subject to combined limits as follows: Physical Therapy - 20 visits per calendar year. Occupational Therapy - 20 visits per calendar year. Speech Therapy - 20 visits per calendar year.	Not covered
21. CARDIAC & PULMONARY REHABILITATION, & POST-COCHLEAR IMPLANT AURAL THERAPY	$25 Copayment per visit. Benefits are subject to combined limits as follows: Cardiac Rehabilitation - 36 visits per calendar year. Pulmonary Rehabilitation - 20 visits per calendar year. Post-Cochlear Implant Aural Therapy - 30 visits per calendar year. Cognitive Rehabilitation therapy - 20 visits per calendar year.	Not covered
22. DURABLE MEDICAL EQUIPMENT	20% after Deductible has been met. Benefits are limited to $2,500 per calendar year.	Not covered
23. HEARING AIDS	Medically necessary hearing aids prescribed by a Network Provider are covered every three years in network. For adults age 18 and over, there is a $2,500 benefit maximum every 3 years. Charges exceeding the $2,500 hearing aid maximum benefit, are the responsibility of the member. Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under office visits and the applicable copayment applies. Hearing aids do not apply to the annual DME limit.	Not covered
24. PROSTHETIC DEVICES	Plan pays 80%. No maximum benefit, does not apply to annual DME limit.	Not covered

	In Network	Out-of- Network
25. ORTHOTICS	Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but must pay out-of-pocket for the orthotic and submit the receipt for reimbursement from DHMP.	
26. OXYGEN	20% after Deductible has been met. Benefits are limited to $2,500 per calendar year.	Not covered
27. ORGAN TRANSPLANTS	20% after: Per Occurrence Deductible of $150 and Annual Deductible have been met (with a referral from your Primary Physician). Only covered at authorized facilities. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed	Not covered
28. HOME HEALTH CARE	20% after Deductible has been met. Benefits are limited to 60 visits for skilled care services per calendar year.	Not covered
29. HOSPICE CARE	20% after Deductible has been met.	Not covered
30. SKILLED NURSING FACILITY CARE	20% after Deductible has been met. Benefits are limited to 60 days per calendar year.	Not covered
31. DENTAL CARE	ACCIDENTAL ONLY 20% after Deductible has been met. Benefits are limited as follows: $3,000 maximum per calendar year. $900 maximum per tooth.	Not covered
32. VISION CARE	$25 Copayment per visit. Benefits are limited to 1 exam every 2 calendar years.	Not covered
33. CHIROPRACTIC CARE	$50 copay per visit. Maximum benefit is 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered
34. SIGNIFICANT ADDITIONAL COVERED SERVICES	• Curves Wellness program. DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least 8 times per month • Snap Fitness discount • Weight Watchers Discount. DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • Jenny Craig discount: members receive a discount on enrollment and 25% off monthly program costs. • eLearning module for parents-to-be. Online childbirth classes, free of charge to members • Take Control of Your Health incentive plan	Not covered

1 Summary of Benefits

If you have a life or limb-threatening emergency, call 911 or go to the closest hospital emergency department or nearest medical facility.

DHMP, Inc. has an access plan which will be made available to members at their request by calling Member Services at 303-602-2100.

Prior authorization is required for, but not limited to, the following services:

Durable Medical Equipment, home health care, including IV therapy, hospital admissions, including substance abuse-related admissions, outpatient surgery, prescription drugs that require pre-authorization as listed in the DHMP formulary (DHMP formulary can be found on our website at www.denverhealthmedicalplan.com), skilled nursing facility admissions, transplant evaluations and procedures, and hospice care. Contact your Primary Care Physician or Specialist to request these services.

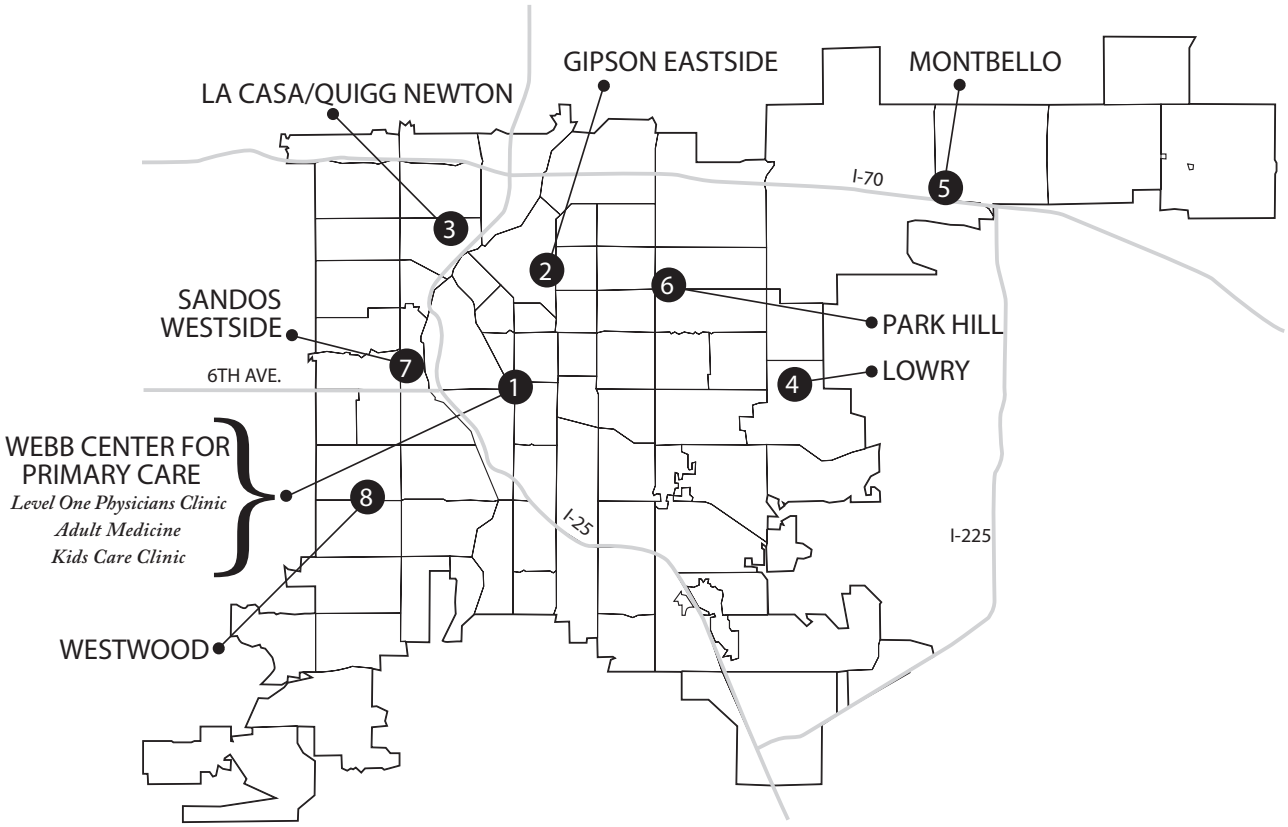
January 2013

ATTENTION DHMP MEMBERS
Career Service Authority and
Denver Employees Retirement Plan Non-Medicare
Deductible HMO (DHMO)

The information contained in this Member Handbook explains the administration of the benefits of Denver Health Medical Plan Inc., (DHMP) a state licensed health maintenance organization (HMO). This Member Handbook is also considered your Evidence of Coverage document. Information regarding the administration of DHMP benefits can also be obtained through DHMP marketing materials, and by contacting the DHMP Member Services Department at 303-602-2100 or 800-700-8140. In the event of a conflict between the terms and conditions of this Member Handbook and any supplements to it and any other materials provided by DHMP, the terms and conditions of this Member Handbook and its supplements will control.

Coverage for Employees of the City and County of Denver and Non-Medicare Members of the Denver Employees Retirement Plan as described in this Member Handbook commences January 1, 2013 and ends December 31, 2013.

3 Contact Us



FAMILY HEALTH CENTERS

WELLINGTON WEBB CENTER FOR PRIMARY CARE
301 W. 6th Ave.

LEVEL ONE PHYSICIANS CLINIC	303.602.8270
ADULT MEDICINE CLINIC	
Burgundy	303.602.8070
Green Team	303.602.8080
KIDS CARE CLINIC	303.602.8340
Rx PHARMACY	303.602.8500

Rx GIPSON EASTSIDE
501 28th St.	303.436.4600
Pharmacy	303.436.4090

Rx LA CASA/QUIGG NEWTON
4545 Navajo	303.602.8700
Pharmacy	303.602.8700

LOWRY
1001 Yosemite St.
Suite 100 303.436.4545

Rx MONTBELLO
12600 E. Albrook Dr.	303.602.4000
Pharmacy	303.602.4025

PARK HILL
4995 E. 33rd Ave. 303.602.3720

Rx SANDOS WESTSIDE
1100 Federal Blvd	303.436.4200
Pharmacy	303.436.4200

WESTWOOD
4320 W Alaska Ave 720.956.2900

HOSPITAL

DENVER HEALTH MEDICAL CENTER
777 Bannock St. 303.436.6000

ADULT URGENT CARE WALK-IN CLINIC
777 Bannock St. 303.602.2822

PEDIATRIC URGENT CARE CLINIC
777 Bannock St. 303.602.3300

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5 Eligibility

5.1 Who is Eligible

You are eligible to participate in the Denver Health Medical Plan-Denver Medical Care if you are:

A regular, full-time or eligible part-time employee who is actively employed with the City and County of Denver, or a non-Medicare member of the Denver Employee Retirement Plan (DERP).

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

Your spouse as defined by applicable Colorado State law (including common-law spouse or same sex domestic partner) if;

A child married or unmarried until their 26th birthday as long as they are not eligible for health care benefits through their employer

An unmarried child of any age who is medically certified as disabled and dependent upon you.

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

For coverage under a qualified medical child support order or other court order, you must provide a copy of the order.

Eligible dependents living outside of the Network Area must use Denver Medical Care network providers for their medical care, except for urgent/emergency care.

For a common-law spouse or same sex domestic partner, you must complete the appropriate paperwork (affidavit) and return it to your employer. This form is available from your employer or the DHMP Member Services Department.

You may not participate in this plan as both an employee and as a dependent.

You may enroll in DHMP without regard to physical or mental condition, race, creed, age, color, national origin or ancestry, handicap, marital status, sex, sexual preference, or political/religious affiliation. No one is ineligible due to any pre-existing health condition. DHMP does not discriminate with respect to the provision of medically necessary covered benefits against persons who are participants in a publicly financed program.

5.2 Enrollment

Initial Enrollment - You and your eligible dependents must enroll in DHMP within the first 30 days of your employment.

Open Enrollment - "Open enrollment" is an annual period of time during which employees may enroll in their employer's health insurance plan if they have not already done so, or may change from one health insurance option to another. You and your eligible dependents may enroll in DHMP during your employer's annual open enrollment period.

Special Enrollment - The occurrence of certain events triggers a special enrollment period during which you and/or eligible dependents (depending on the event) can enroll in DHMP. In each case, you and/or your eligible dependents must enroll within 31 days after the event.

Events that Trigger a Special Enrollment Period:

(1) **Loss of other creditable coverage**: If you were covered under other creditable coverage at the time of the initial enrollment period and lose that coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward such coverage, you may request enrollment in DHMP.

If an eligible dependent was covered under other creditable coverage at the time of the initial enrollment and loses

the coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward such coverage , your eligible dependent may request enrollment in DHMP if you are a member of DHMP.

(2) **Court Order:** If you are a DHMP member and a court orders you to provide coverage for a dependent under your health benefit plan, you may request enrollment in DHMP for your dependent.

(3) **New Dependents:** If you are a DHMP member and a person becomes a dependent of yours through marriage, birth, adoption, or placement for adoption, you may request enrollment of such a person in DHMP. In such a case, coverage will begin on the date the person becomes a dependent.

(4) **Newborn Children**: Your newborn child(ren) is (are) covered for the first 31 days after birth. For coverage to continue beyond the first 31 days, you must complete and submit an enrollment change form within those first 31 days to add your newborn child(ren), and pay the required premiums. The form is available from your employer. For additional information, call Member Services at 303-602-2100 or 800-700-8140.

Deletion of Dependents (changes in eligibility)

You must inform the DHMP Member Services Department within 31 days if a death, divorce, marriage or other event occurs which changes the status of your dependents. Those who are no longer eligible will lose coverage under the Plan, unless they qualify for continuation or conversion coverage (see section 12).

Dependents of Dependents (Grandchildren)

Children of a dependent are not covered for any period of time, including the first 31 days of life, unless court-ordered custody is awarded to the DHMP subscriber. You must provide a copy of the court order to DHMP along with the enrollment form.

5.3 When Coverage Begins

New Employees - If you are a new employee, have completed the DHMP enrollment process and paid the premiums required for coverage, your coverage begins on the first day of the calendar month following the month in which you began work. Coverage for your enrolled dependents begins when your coverage begins.

Open Enrollment - If you select DHMP during an annual open enrollment period, your coverage begins on January 1 of the following year. Coverage for your enrolled dependents begins when your coverage begins.

Newborn Children - Your newborn children are covered for the first 31 days after birth. You must complete and submit an enrollment change form within 31 days of birth to add your newborn children, and pay the required premiums, for coverage to continue beyond the first 31 days.

Other New Dependents - If you enroll any other new dependent, such as a new spouse, an adopted child or child placed for adoption, within 31 days of marriage, adoption or placement for adoption, coverage will be retroactive to the date of the event causing the change to dependent status.

Confined Members - If a member is confined to a medical facility at the time coverage begins and the member had previous coverage under a group health plan, the previous carrier will be responsible for all covered costs and services related to that confinement. DHMP will not be responsible for any services or costs related to that confinement. However, should any services be required that are not related to the original confinement, DHMP will be responsible for any services that are covered as stated in Section 7 - Benefits/Coverage. If the member is confined to a medical facility and was not covered by a group health plan when DHMP coverage began, DHMP will be responsible for the covered costs and services related to the confinement from the time coverage begins.

5.4 When Coverage Ends

Your coverage will end at 11:59 p.m. on the last day of the month in which you become ineligible.

A member may become ineligible when:

- A newborn dependent, new spouse, adopted child or child placed for adoption is not enrolled within the first 31 days of birth, marriage, adoption or placement;
- You are no longer a regular, full-time or eligible part-time employee who is actively employed for an enrolled employer group, unless you qualify for continuation or conversion coverage (see section 12);
- You retire and do not select DHMP under your employer's retirement plan;
- You are a dependent who no longer meets eligibility requirements, unless you qualify for conversion or continuation coverage (see section 12);

- You exhaust any continuation coverage for which you were eligible;
- You no longer pay the monthly premium required for continuation coverage;
- Your employer terminates coverage under the Plan;
- Your employer fails to make the required premium payments;
- You commit a violation of the terms of the Plan (see section 5.5).

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

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

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

Medicare Eligibility for Age or Disability Eligible Employees (Actively Working)

If you become eligible for Medicare by reason of age or disability while covered on this Plan, you must enroll in Medicare Part A. During any waiting period for Medicare coverage to begin (usually 24 months for disability), your coverage under this Plan will continue unchanged. Once the waiting period is over, you must make one of the following two choices:

1. Continue your coverage with DHMP while you are an eligible current employee. If you do so, DHMP will provide and pay for benefits as if you were not eligible for or enrolled in Medicare, i.e., DHMP will be your primary coverage. Medicare will pay for costs not paid by DHMP, i.e., Medicare will be your secondary coverage.
2. Select Medicare as your coverage while you are an eligible current employee. If you do so, your coverage with DHMP will terminate, as required by law. However, your covered dependents may be eligible for continuation coverage. See Section 12 for more information about continuation coverage. You should consider enrollment in Medicare Part B when Medicare is your only coverage.

Retired Employees

If you become eligible for Medicare by reason of age, your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. Call Member Services for details. The coverage of your dependents will also terminate. However, your covered dependents may be eligible for continuation coverage. See Section 12 for more information about continuation coverage.

If you become eligible for Medicare before age 65 by reason of disability and are covered on this Plan as a retiree, you must enroll in Medicare Part A. During any waiting period for Medicare coverage to begin (usually 24 months for disability), your coverage under this Plan will continue unchanged. Once the waiting period is over, Medicare will be your primary coverage. Your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. You will be responsible for paying the Medicare Part B premium. Call Member Services for more details.

If you continue on this Plan, your dependents may also continue on this Plan, with benefits unchanged. If you choose Medicare coverage only, the coverage for your dependents on this Plan will terminate. However, your covered dependents may be eligible for continuation coverage. See Section 12 for more information about continuation coverage.

The following information is applicable to individuals eligible for Medicare due to End Stage Renal Disease (ESRD).

Medicare Eligibility for End Stage Renal Disease (ESRD) Eligible Employees and Retirees

If you become eligible for Medicare before age 65 by reason of end stage renal disease (ESRD) and are covered on this Plan, you must enroll in Medicare Part A but DHMP will continue to provide and pay for benefits as if you were not eligible for or enrolled in Medicare, i.e., DHMP will be your primary coverage, for a period of 30 months after your you are eligible for Medicare – this period is called the coordination period because Medicare will coordinate with DHMP coverage and may pay for costs not paid by DHMP. Once the coordination period is over (or sooner if you are no longer an eligible employee), Medicare will be your primary coverage. If you are an Eligible Employee (actively working), you may continue your coverage under this Plan. If you do so, this Plan will be your secondary coverage and will pay costs not paid by Medicare Parts A and B, such as the Medicare Parts A and B deductibles and coinsurance amounts. One condition of secondary coverage under this Plan is that you must enroll in Medicare Part B. If you become eligible for Medicare by reason of end

stage renal disease (ESRD) you must enroll in Medicare Part B or you will be terminated from the plan. You will be responsible for paying the Medicare Part B premium but you may be eligible for reimbursement of the Part B premium amount from your former employer or the Plan. There is no requirement to enroll in Medicare Part D. If you are a Retiree, when Medicare is your primary coverage, your coverage under this Plan will terminate. However, you may be eligible for a Medicare product offered by DHMP. Call Member Services for more details.

5.5 Special Situations: Termination of Coverage

Under certain circumstances, your coverage or that of one or more of your dependents, may be terminated by DHMP. These circumstances are described below. You may use the complaint and appeal process available through DHMP if you feel there is a valid reason why coverage should not be terminated.

Non-Payment of Copayments - If a member does not pay required copayments or does not make satisfactory arrangements to pay copayments, DHMP may terminate the member with not less than 31 days written notice.

Inappropriate Behavior - If a member's behavior is disruptive, unruly or abusive to the extent that the ability of DHMP or a provider to render services to the member or other members is impaired, DHMP may terminate the member upon 31 days written notice. When possible, DHMP will attempt to resolve the problem, including the use of the complaint process. Behavior resulting from mental illness or reaction to treatment or medication will be taken into consideration.

False or Misleading Information - If a member attempts to obtain benefits under DHMP by means of false, misleading, or fraudulent information, acts or omissions for themselves or others, DHMP may terminate the member's coverage upon seven days written notification.

Misuse of Identification Card - The DHMP identification card is solely for identification purposes. Possession of the card does not ensure eligibility and/or rights to services or benefits. The holder of the card must be a member for whom all premiums under the Plan have been paid. If a member allows the use of his/her DHMP identification card by any other person, DHMP may terminate the member's coverage upon seven days written notice. Payment for services received as a result of the improper use of a DHMP identification card is the responsibility of the individual who received the services.

5.6 Special Situations: Extension of Coverage

Medical or Personal Leaves of Absence - If you are on an approved medical or personal leave of absence, including leave under the Family and Medical Leave Act, coverage will continue in accordance with your employer's policies and procedures.

Military Leave of Absence - If you are on an approved military leave of absence, coverage may continue for the duration of the leave. Payment must be made in accordance with your employer's policies and procedures.

Standard Leave of Absence - A member who elects to take authorized Standard Leave of Absence may be eligible for coverage as permitted by Career Service Rules. The Family Medical Leave Act of 1993 (FMLA) allows a worker up to 12 weeks of leave under certain circumstances.

6 How to Access Services and Obtain Approval of Benefits

6.1 Welcome to the Denver Health Medical Plan, Inc.

At Denver Health Medical Plan, Inc. (DHMP), our main concern is that you receive quality health care services.

As a member of DHMP's Medical Care Plan, you must receive your health care services within the Denver Medical Care network and you will pay small copayments for most services.

Your basic membership obligation is to consult with your primary care provider (PCP) before seeking most health care services.

The Denver Medical Care network includes: Denver Health and Hospital Authority and the Denver Health and Hospital Authority providers located on the Denver Health campus, as well as Denver Health and Hospital Authority neighborhood health care facilities that are conveniently located throughout the Denver metropolitan area. Denver Health offers a privately insured clinic, Level One Physicians Clinic located on the main Denver Health and Hospital Authority campus. Please refer to your Denver Medical Care provider directory for a complete listing of providers. A map of clinic locations can be found at the beginning of this book.

Please see the Summary of Benefits Form in Section 1 for a breakdown of copayments.

6.2 Member Handbook

This handbook contains information that will enable you to use DHMP efficiently and effectively, and help you to get the most from your health plan. This handbook supercedes all previous handbooks. Benefits and procedures may change from time to time so it is important that you use the most recent handbook as your reference. This handbook serves as your evidence of coverage. If you have a question regarding the information in this handbook, please contact the DHMP Member Services Department at 303-602-2100 or 800-700-8140.

6.3 Receiving Care through Denver Health Medical Plan, Inc.

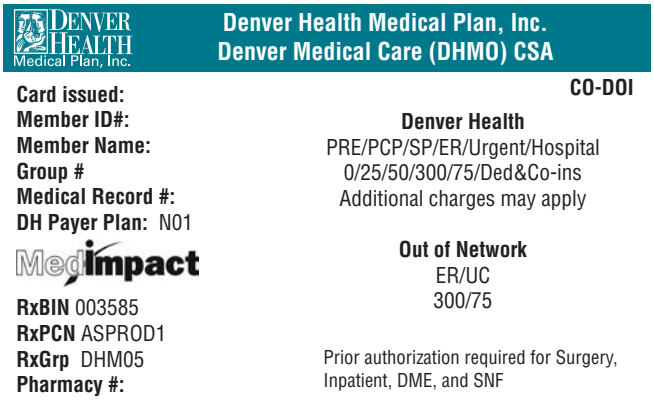
When you join DHMP, you will receive your care within the Denver Medical Care network.

Here are some things you can do to get quality service:

- Carry your DHMP identification card and present it wherever you receive health care services. Always bring a picture ID to your appointment.
- Select your primary care provider (PCP) right away and call your PCP first when you think you need care (except if there is a life or limb threatening emergency). Call the Member Services Department at 303-602-2100 or 800-700-8140 to select your PCP. The provider directory is located online at www.denverhealthmedicalplan.com.
- Become familiar with the benefits that are covered under the plan.

Your DHMP Identification Card

Keep your DHMP identification card with you at all times. Before receiving medical or prescription services, you must show your DHMP identification card. If you fail to do so, or misrepresent your membership status, claims payment may be denied.



Your Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is the practitioner (physician, nurse practitioner, or physician assistant) you choose from the Denver Medical Care network who supervises, coordinates and provides your initial and basic care, initiates referrals for specialist care and maintains the continuity of your care. The relationship between you and your PCP is the key to receiving health care benefits through DHMP. PCPs can be Family Practice, Internal Medicine or Pediatric practitioners.

Your PCP is your partner in your personal health care management, providing most of your care and coordinating other care as necessary.

Services should be provided or referred by your PCP. You do not need a PCP referral for life or limb-threatening emergency care or urgent care in or out-of-network, you can self-refer for in network outpatient mental health care, routine eye exam, chiropractic care and OB/GYN care for women. When living or traveling outside of the network, only emergencies, urgent care services and your prescription costs will be covered in network.

Selecting Your Primary Care Provider (PCP)

You need to choose a PCP in order to receive DHMP covered benefits. Each family member may select a different PCP. If you have not yet chosen a PCP, please do so right away by calling the Member Services Department at 303-602-2100 or 800-700-8140. A Member Services Representative can help you select a PCP. Your provider directories are available online at www.denverhealthmedicalplan.com.

Working With Your Primary Care Provider (PCP)

When you need non-emergency medical care, call your PCP and he/she will provide necessary treatment and make referrals to specialists when appropriate. Your PCP may refer to any specialist in the Medical Care network. If you require ongoing care from a specialist, your PCP may issue a standing referral within the Denver Medical Care network for a period of up to one year. The standing referral will allow you to see the specialist for treatment of a specified condition, during the stated period, without having to get a referral from your PCP each time a visit to the specialist is required. Even if you have a standing referral, you must continue to see your PCP for your primary care. Referrals to in network specialists must be initiated by your PCP, but do not require authorization by DHMP. If you believe that a second opinion is needed about a course of treatment that has been recommended for you by a specialist or your PCP, preauthorization for the second opinion may be initiated by your PCP or your specialist.

You may self-refer for emergency care, urgent care, and for the following services in the DHMP Medical Care network: OB/GYN care, outpatient mental health care and Columbine Chiropractic care.

If you choose to see a provider or specialist who does not participate in the Denver Medical Care network without a referral and without authorization, you will be responsible for all charges, including charges for hospital care. DHMP has no obligation to pay these charges, which can accumulate much more rapidly than you anticipate. Note: In a case of emergency, you may go to any physician or facility, in or out-of-network.

Changing Your Primary Care Provider (PCP)

You can change your PCP at any time by calling the Member Services department at 303-602-2100 or 800-700-8140. The change will take effect the first day of the month following your call.

When a PCP leaves that you have received treatment from the Denver Medical Care network will notify you in writing. You will need to pick a new PCP or one will be assigned.

Contact your new PCP before you receive further specialist care.

Access Plan

DHMP has an Access Plan that lists all hospitals and other providers in the network and explains, in detail, DHMP's referral procedures, grievance procedures and emergency coverage procedures. You may request to see the Access Plan by calling the Member Services Department at 303-602-2100 or 800-700-8140.

When you are out of town

If you plan to be outside the DHMP service area and need your prescription filled while you are gone, we have a broad network of pharmacies across the United States to accommodate you. Please check with Member Services for more information.

Change of address

If you change your name, mailing address, or telephone number, contact your Benefits Manager.

6.4 How to Get Help

If you have any questions or need to contact DHMP for any reason, call the Member Services Department 303-602-2100 or 800-700-8140 for assistance. TTY/TDD call 303-602-2129.

6.5 Advance Directives

Federal law directs that any time you are admitted to any health care facility, or served by certain organizations that receive Medicaid or Medicare money, you must be given information about Colorado's laws concerning your right to make health care decisions. Such decisions include the right to consent to (accept) or refuse any medical care or treatment, and the right to give advance directives. Advance directives are written instructions concerning your wishes about your medical treatment. These are important health care decisions and they deserve careful thought. It may be a good idea to discuss them with your doctor, family, friends, or staff members at your health care facility, and even a lawyer. You can obtain more information about advance directives, such as living wills, medical durable powers of attorney, and CPR directives (do not resuscitate orders) from your PCP, local hospital, or lawyer. You are not required to have any advance directives to receive medical care or treatment. Advance Directive forms are available on the DHMP web site at www.denverhealthmedicalplan.com.

7.1 Benefits

Your DHMP Benefits

When you join DHMP, the quality of your care is monitored through our Quality Improvement Program.

DHMP evaluates new medical technologies and the new application of existing technologies for inclusion in the benefit package, including medical procedures, pharmaceuticals and devices.

It is important that you understand which benefits and copayment obligations apply to you. When in doubt, call the DHMP Member Services Department at 303-602-2100 or 800-700 8140. DHMP is the best source for information about your health care plan benefits.

Member Newsletter

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

Behavioral Health and Wellness Program

As a DHMP member, you have access to our Behavioral Health and Wellness program. The program includes health coaches that can assist you with healthy lifestyle choices, managing chronic conditions, and navigating through the DH system. For more information, call Behavioral Health & Wellness at 303-602-2188.

7.2 Covered Medical Services

Chiropractic Services

Chiropractic care is covered when received from a Denver Medical Care Network provider. Please refer to the Columbine Chiropractic Plan Directory for a list of participating Chiropractors. Self-referral is allowed. Service exclusions (e.g. acupuncture, massage therapy) may apply. Acupuncture and massage therapy are NOT a covered benefit. However, the plan does offer a discount program for these services. See Special Programs on the web site at: www.denverhealthmedicalplan.com or look in your Quick Reference Guide.

In network: $50 copay per visit, Columbine Chiropractic only

Out-of-network: Not covered

Benefit Maximum: 20 visits per calendar year

Clinic (Outpatient) Services

- **Office Visits**

Primary Care Services provided by your PCP are covered. Referrals to specialists, unless otherwise specified in this handbook, must be made by your PCP. Phone consultations are not subject to copayments. For information about preventive care services, please refer to the *Preventive and Health Maintenance Medical Management* section of this book.

Allergy, immunization and other injections given by a nurse received in an office setting when no other services are provided are not subject to office visit copayments.

Primary Care:

In network: $25 per visit

Out-of-network: Not covered

Specialty Care:

In network: $50 per visit

Out-of-network: Not covered

- **Clinics Outside the Health Plan Network**:

  Specialty outpatient care outside of the Denver Medical Care Network may be covered if:

  (1) The type of care is not provided within the Denver Medical Care Network, and

  (2) You receive a referral from your PCP, and

  (3) The referral is approved (authorized), in advance, by DHMP.

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

  When living or traveling outside of the Denver Metropolitan area, only emergencies, urgent care services, and prescriptions in network pharmacies will be covered.

Diabetic Education and Supplies

If you have elevated blood glucose levels and have been diagnosed as having diabetes by an appropriately licensed health care professional, you are eligible for outpatient self-management training and education, as well as coverage of your diabetic equipment and supplies, including glucometers, test strips, insulin and syringes. These supplies are provided by your pharmacist with a prescription from your physician. Insulin pumps are covered through the DME benefit, which covers a maximum of $2000 per calendar year for all of your durable medical equipment (DME) needs.

Dietary and Nutritional Counseling

Coverage for dietary counseling is limited to the following covered situations:

- New onset diabetic.
- Weight reduction counseling by a dietitian.

Durable Medical Equipment and Supplies

- **General**
  Durable medical equipment (DME) is covered if medically necessary and prior authorized by the DHMP Medical Management department. The prior authorization will specify whether the equipment will be rented or purchased. Rentals are authorized for a specific period of time. If you still need the rented equipment when the authorization expires, you should call your PCP and request that the authorization be exten ded. Except for certain supplies, such as oxygen the copayment for DME is as stated in the Summary of Benefits. All DME must be obtained from a Denver Medical Care Network provider. Repair of equipment is covered with no additional copay if the repair is needed due to normal usage; repair due to misuse/abuse is not covered. Replacement of equipment due to normal usage is covered and the DME benefit maximum and copay apply.

  You are responsible for the entire cost of lost, stolen or damaged equipment (other than normal usage).

  In network: 20% copay of total cost

  Out-of-network: Not covered

  Benefit Maximum: $2500 per member per calendar year

All of the specific types of DME described below are subject to the general conditions of coverage above unless otherwise stated.

- **Braces**

  Braces for scoliosis and braces for an acute condition (within six months of a new injury or surgery) are covered.

- **Dressings/Splints/Casting/Strapping**

  Dressings/splints/castings/strappings that are given to you by a provider are covered and no copayment is required. The cost of purchased dressings/splints/castings/strappings apply to the DME benefit maximum of $2500 per calendar year and the 20% copay applies. NOT COVERED Out-of-Network.

- **Oxygen/Oxygen Equipment**

  Equipment for the administration of oxygen is covered and subject to DME copayments. Oxygen is covered, and no copayment is required. THE COST OF OXYGEN EQUIPMENT AND OXYGEN WILL NOT APPLY TO THE ANNUAL DME BENEFIT MAXIMUM.

Early Intervention Services

Early intervention services are covered for an eligible dependent from birth to age 3 who has, or has a high probability of having, developmental delays, as defined by state and federal law, and who is participating in Part C of the federal Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq.

Early intervention services are those services that are authorized through the eligible dependent's individualized family service plan, including physical, occupational and speech therapies and case management. A copy of the individualized family service plan must be furnished to the DHMP Medical

Management department. All services must be provided by a qualified early intervention service provider who is in the DHMP Network, unless otherwise approved by Medical Management department.

No copayments apply to early intervention services.

Benefit Maximum: $6,361 for all early intervention services per calendar year.

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

Emergency Services

For life or limb-threatening emergencies, you should call 911 or go to the nearest hospital emergency department.

Services for the treatment of an emergency are covered. See definition of "Emergency," Chapter 9. If you are admitted to the hospital directly from the Emergency Department, you will not have to pay the emergency department copayment, but will be responsible for the inpatient copayment.

In network: $300 copay per visit

Out-of-network: $300 copay per visit

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

Follow-up care following an emergency department visit must be received from a Denver Medical Care Network provider, unless you are traveling outside the Network Area and prior authorization is obtained. If you are admitted to a non-Denver Health hospital as the result of an emergency and then subsequently transferred to Denver Health, you will only be responsible for the copayment for the first inpatient hospital admission.

- **Ambulance Service**

  Medically necessary ambulance services related to the treatment of an emergency are covered.

  Use of ambulance services should be reported to DHMP as soon as reasonably possible, preferably within 48 hours, even if you are treated at Denver Health and Hospital Authority. Please call Medical Management department at 303-602-2140.

  In network: 20% after annual deductible has been met.

  Out-of-network: 20% after annual deductible has been met.

- **Urgent Care Services**

  Urgent care services received within the Denver Medical Care Network are covered. Urgent care services are those required in order to treat and prevent a serious deterioration in health but which do not rise to the level of an emergency. After working hours you may also, call the NurseLine at 303-739-1261.

  In network: $75 copay

  Out-of-network: $75 copay

  In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.

  If you are traveling or temporarily absent from the Denver area and need emergency or urgent care services, DHMP will pay out of-network providers directly or reimburse you for these services.

  Follow-up care after an emergency visit must be received from a Denver Medical Care Network provider, although if you are traveling outside the Denver area authorization can be obtained for one follow up visit. A separate copayment will be required. Notes: Travel expenses back to the Denver Medical Care Network Area are not a covered benefit.

Eye Examinations and Ophthalmology

- **Routine Visual Screening Exam**

  Routine vision examinations, including refraction to detect vision impairment, received from a health care provider in the provider's office are covered once every 24 months.

In network: $25 copay

Out-of-network: Not covered

Artificial Eyes (see under Prosthetics).

Exclusion: Optometric Vision Therapy/Treatment

Family Planning and Infertility Services

- **Family Planning Services**

  The following are covered if obtained from a provider in the Denver Medical Care Network:

  - Family planning counseling
  - Pre- and post-abortion counseling
  - Information on birth control
  - Diaphragms (and fitting)
  - Insertion and removal of intrauterine devices
  - Contraceptives (oral) (see Medicine/Pharmacy)

    In network: Covered by office copay.

    Out-of-network: Not covered.

    You do not need a referral from your PCP to obtain services from any gynecologist in the Denver Medical Care Network. Specialist copays will apply.

- **Family Planning Procedures**:
  - Tubal ligations
  - Vasectomies
  - Abortions up to the 15th week of pregnancy

    In network: Applicable copay, deductible, and coinsurance

    Out-of-network: Not covered

    Vasectomies are covered. You must receive a referral from your PCP to a participating urologist, if the service is not provided by your PCP.
    There are some limitations; please see exclusions.

- **Infertility Services**

  In network: Not covered

  Out-of-network: Not covered

Habilitative Services

Medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered even if the purpose of the therapy is to maintain functional capacity.

In network: $25 copay per visit

Out-of-network: Not covered

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy. See "Early Intervention Services" for the benefit maximum for therapies for children to age three.

Hearing Aids

For adults age 18 and over, there is a $2,500 benefit maximum. Charges exceeding the $2,500 hearing aid maximum benefit, are the responsibility of the member. Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under clinic visits and the applicable copayment applies. Hearing aids are no longer part of the DME benefit.

- **Adults**:

  In network: Copay 20% of total cost with a maximum benefit of $2,500. Member responsible for amount over $2,500

  Out-of-network: Not covered

- **Children** (Under age 18):

  In network: No cost

  Out-of-network: Not covered

  Benefit Maximum: Not covered more frequently than every 3 years. Adult: $2,500; Children: No limitation

  Cochlear implants are covered for children under 18 with prior authorization. The device is covered at 100%. Appropriate copay, will apply to surgical services associated with the device.

Home Health Care

Home health care provided by a Denver Medical Care Network home health care provider is covered. Coverage requires periodic assessment by your PCP. A referral by your PCP and prior authorization by DHMP are required.

- **Newborn and Post-partum**

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

- **Physical, Occupational and Speech Therapy**

  Physical, occupational and speech therapy, as well as audiology services, in the home are covered when prescribed by your PCP or specialist and prior authorized by the DHMP Management. Periodic assessment and prior authorization are required to continue therapy beyond the time specified by the initial referral.

  Generally, home physical therapy, occupational therapy and speech therapy and audiology services will be authorized only until maximum medical improvement is reached or the patient is able to participate in outpatient rehabilitation. However, early intervention services for children up to age three with developmental delays and medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered, even if the purpose of the therapy is to maintain functional capacity. See "Early Intervention Services" for more detail about the therapies authorized.

- **Skilled Nursing Services**

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

- **Other Services**

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

  In network: 100% covered

  Out-of-network: Not covered

Hospice Care

Inpatient and home hospice services for a terminally ill member are covered when provided by an approved hospice program. Each hospice benefit period has a duration of three months. Hospice Services must be prior authorized by DHMP Medical Management department before you receive your care.

Hospice benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less. Any member qualifying for hospice care is allowed two 3-month hospice benefit periods. Should the member continue to live beyond the prognosis for life expectancy and exhaust his/her two 3-month hospice benefit periods, hospice benefits will continue at the same rate for one additional benefit period. After the exhaustion of three benefit periods, DHMP Medical Management department will work with the individual's attending physician and the hospice's medical director to determine the appropriateness of continuing hospice care. Services and charges incurred in connection with an unrelated illness or injury are processed in accordance with the provisions of this Handbook that are applicable to that illness or injury and not under this section.

- **Home Hospice Care**

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

  - Physician visits by hospice physicians;
  - Intermittent skilled nursing services of an RN or LPN and 24 hour on-call nursing services;
  - Medical supplies;
  - Rental or purchase of durable medical equipment;
  - Drugs and biologicals for the terminally ill member;
  - Prosthesis and orthopedic appliances;
  - Diagnostic testing;
  - Oxygen and respiratory supplies;
  - Transportation;

- Respite care for a period not to exceed five continuous days for every 60 days of hospice care - no more than two respite care stays are available during a hospice benefit period (respite care provides a brief break from total care giving by the family);

- Pastoral counseling;

- Services of a licensed therapist for physical, occupational, respiratory and speech therapy;

- Bereavement support services for the family of the deceased member during the twelve-month period following death, up to a maximum benefit of $1,150;

- Intermittent medical social services provided by a qualified individual with a degree in social work, psychology, or counseling and 24 hour on-call services. Such services may be provided for purposes of assisting family members in dealing with a specified medical condition;

- Services of a certified nurse aide or homemaker under the supervision of an RN and in conjunction with skilled nursing care and nurse services delegated to other assistants and trained volunteers;

- Nutritional counseling by a nutritionist or dietician and nutritional guidance and support, such as intravenous feeding and hyperalimentation;

Any supplies outside of the usual and customary supplies must be prior authorized by the DHMP Medical Management department.

Hospital (Inpatient) Services

Any admission to a hospital, other than an emergency admission, must be to a Denver Medical Care Network hospital and must be prior authorized by the DHMP Medical Management department. Emergency hospitalization should be reported to DHMP at 303-602-2140 as soon as reasonably possible, preferably within 48 hours.

- Hospital services, including surgery, anesthesia, laboratory, pathology, radiology, radiation therapy, respiratory therapy, physical therapy, occupational therapy and speech therapy are covered. Oxygen, other gases, drugs, medications and biologicals (including blood and plasma) as prescribed are also covered. See Chapter 4 - General Exclusions for non-covered services.
- General inpatient nursing care is covered. Private duty nursing services are not covered. Sitters are covered only when medically necessary and prior authorized.
- Accommodations necessary for the delivery of medically necessary covered services are covered, including bed (semi-private room when available), meals and services of a dietitian; use of operating and specialized treatment rooms; and use of intensive care facilities.

  In network: 20% after annual deductible and per occurrence dectible of $150 are both met.

  Out-of-network: Not covered

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

Immunizations

- There is no copay for immunizations. Immunizations for international travel, Hepatitis A and B, and Meningococcal vaccines will also be covered at no cost. Some international travel immunizations will only be covered at the Public Health Department at Denver Health. Prophylactic drugs for travel will be covered if prescribed by your PCP and if the drugs are on the DHMP formulary. Some immunizations can be received in your PCP's office, so before visiting the Public Health department at Denver Health, contact your PCP first for immunizations and prophylactic drugs.
- HPV vaccine is covered for eligible females and males in accordance with guidelines of the U.S. Department of Health and Human Services when ordered by your provider.
- Clinic visits for administration of immunization do not require a copayment. However, if the visit is a combination of the injection and a PCP, or specialist visit the required copayment will be requested.

Infusion Services

All infusion services including chemotherapy.

In network: 20% after annual deductible is met

Out-of-network: Not covered

Injection Administration

In network: 20% after annual deductible is met*

Out-of-network: Not covered

*The injection copay applies to complex injections that must be given by a physician. An allergy shot, immunization or any injection given by a nurse will not require a copayment. However, if the visit is a combination of the injection and a PCP or specialist visit the required copayment will be requested.

Laboratory and Pathology Services (Outpatient)

All medically necessary laboratory and pathology services and testing ordered by your PCP or specialist or resulting from emergency care are covered.

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

In network: 20% after annual deductible is met

Out-of-network: Not covered

Maternity Care

- **Prenatal Care**

  Office visits, physician services, laboratory and radiology services necessary for pregnancy, when such care is provided by a network provider, are covered. You may obtain obstetrical services from your PCP or any network obstetrician. You do not need a referral from your PCP to see a participating OB/GYN, physician, Certified Nurse Midwife or Nurse Practitioner. Expectant mothers are encouraged to limit travel out of the Denver Metro area during the last month of pregnancy. If a "high-risk" designation applies, mothers should limit non-emergency travel within two months of expected due date.

  In network: $25 copay per visit for all prenatal visits and the first post partum visit.

  Out-of-network: Not covered

- **Delivery (Vaginal or Cesarean)**

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

  Mother and child may have a minimum hospital stay of 48 hours following a vaginal delivery or 96 hours following a Cesarean delivery, unless mother and attending physician mutually agree to a shorter stay. If 48 hours or 96 hours following delivery falls after 8:00 p.m., the hospital stay will continue and be covered until at least 8:00 a.m. the following morning.

  In network: 20% after annual deductible is met*

  Out-of-network: Not covered

  Limitations: Home deliveries are not covered

Medical Food

Medical food is covered for metabolic formulas to treat enzymatic disorders caused by single gene defects. Enteral (by tube) or Parenteral (by intravenous infusion) nutrition– if member has non-function or disease of the structures that normally permit foot to enter the small intestine or impairment of small bowel that impairs digestion and absorption of an oral diet.

Exclusions:

Standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases, including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; intolerances to soy formulas or protein hydrolysates; prematurity; or low birth-weight

- Food thickeners
- Dietary and food supplements
- Lactose-free products; products to aid in lactose digestion
- Gluten-free food products
- Weight-loss foods and formula
- Normal grocery items
- Low carbohydrate diets
- Baby food
- Grocery items that can be blenderized and used with enteral feeding system
- Nutritional supplement puddings
- High protein powders and mixes
- Oral vitamins and minerals

	Preferred Generic (Tier 1)	Preferred Brand (Tier 2)	Non-Preferred (Tier 3)
DH Pharmacy (30 day supply)	**$12**	**$40**	**$50**
DH Pharmacy or Pharmacy Delivery by mail (90 day supply)	**$24**	**$80**	**$100**
Non-DH Pharmacy (30 day supply) (Examples: King Soopers, Target, etc.)	**$20**	**$50**	***$80**
Non-DH Pharmacy (90 day supply) (Examples: King Soopers, Target, etc.)	**$40**	**$100**	***$160**

*Prior Authorization Required

Mental Health Services

- **Inpatient Psychiatric/Mental Health Services**

  Inpatient psychiatric care is covered at a Denver Medical Care Network facility.

  Prior authorization is required for non-emergency admissions. Notification to DHMP should be made as soon as reasonably possible, preferably within 48 hours of an emergency admission.

  In network: 20% after annual deductible and per occurrence dectible of $150 are both met.

  Out-of-network: Not covered

- **Partial Hospitalization/Day Treatment**

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

  Virtual Residency Therapy is considered outpatient care and the outpatient copay applies for each day of service.

  In network: $50 copay per day, whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

- **Outpatient Psychiatric/Mental Health Services**

  Individual and group psychotherapy sessions are covered. You may obtain mental health services from any mental health professional in the Denver Medical Care Network or in the Cofinity network without a referral from your PCP.

  In network: $50 copay per visit, whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

  No benefit maximum

  There is no copayment for phone consultations with your mental health provider.

- **Marital Counseling, Stress Counseling and Family Therapy**

  Marital and couples counseling, family therapy and counseling for stress-related conditions are covered. You may obtain these services from any mental health professional in the Denver Medical Care Network without a referral from your PCP.

  In network: $50 copay per visit, Whether an individual or group visit. (Denver Health or Cofinity network providers)

  Out-of-network: Not covered

- **Biologically-based Mental Illnesses and Mental Disorders**

  DHMP will provide coverage for the treatment of biologically-based mental illnesses and mental disorders that is no less extensive than for any other physical illness. Biologically-based mental illnesses are: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder. "Mental Disorders" are defined as post-traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa, and anorexia nervosa. Residential treatment, including for bulimia nervosa and anorexia nervosa, is not a covered benefit.

  In network:

  Inpatient: 20% after annual deductible and per occurrence deductible of $150 are both met.

  Outpatient: $50 copay per visit, whether an individual or group visit. (Denver Health or Cofinity

network providers)

Out-of-network: Not covered

No benefit maximum

Newborn Care

All in-network hospital, physician, laboratory and other expenses for your newborn are covered, including a well child examination in the hospital. During the first 31 days of your newborn's life, benefits consist of coverage for any injury or sickness treated by a Denver Medical Care Network provider, including all medically necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, regardless of any limitations or exclusions that would normally apply under the plan. Applicable copay will apply. You must enroll your newborn in DHMP during the first 31 days of life for coverage to continue beyond the first 31 days. Refer to the *Eligibility Section*. Children of a dependent child are not covered for any period of time, even the first 31 days.

DHMP covers all medically necessary care and treatment for newborn children with cleft lip or cleft palate or both, including oral and facial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, habilitative speech therapy, speech appliances, feeding appliances, medically necessary orthodontic and prosthodontic treatment; otolaryngology treatment and audiological assessments and treatment. Care under this provision for cleft lip or cleft palate or both will continue as long as the member is eligible. All care must be obtained through Denver Medical Care Network providers and must be prior authorized by the DHMP Medical Management department. If a dental insurance policy is in effect at the time of birth, or is purchased after the birth of a child with cleft lip or cleft palate or both, the Plan will follow coordination of benefit rules.

Observational Hospital Stay

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

An observational hospital stay is covered with prior authorization, or if it resulted from an emergency department visit. If you are admitted into Observation after receiving services in the emergency department, you will not have to pay the emergency department copayment, but you will be responsible for the observational stay copayment.

In network: $300 copay per observational stay

Out-of-network: $300 copay per observational stay

Orthotics

Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but must pay out-of-pocket for the orthotic and submit the receipt for reimbursement from DHMP. Benefit Maximum for Shoe Orthotics: $50 per calendar year. (See Section 10.1: "How to File a Claim" for information on how to get reimbursed.)

Ostomy Supplies

Colostomy, ileostomy and urostomy supplies are covered.

Pharmacy Benefits

DHMP provides a drug coverage benefit. Depending upon where you have your prescription filled, copays and restrictions may vary. Please see the Pharmacy Benefits chart below.

- **Participating Pharmacies**

Your copay will always be less when you fill your prescriptions at one of the many Denver Health Pharmacies. Denver Health Pharmacies offer a "Discounted Copay List" for DHMP members. You can find the current list of eligible drugs at www.denverhealthmedicalplan.com or by calling Member Services.

Remember, in order to fill a prescription at a Denver Health Pharmacy, it must be written by a Denver Health Provider.

Denver Health Refill Request Line
1-866-347-3345

Denver Health Pharmacy by Mail (requires credit card registration/order form)
303-602-2326

Preventive Care Service	You Pay (for services from a Denver Health Provider)	Out-of-Network
Adult annual preventive care exams *As well as all screenings rated A or B by the U.S. Preventive Services Task Force (USPSTF) *Age-appropriate adult preventive care screenings including but not limited to:* • Cholesterol (lipid profile) screening • Mammograms • Screening colonoscopy/sigmoidoscopy	$0 copay/office visit There is no additional charge for these tests	Not covered
Well-woman exams including: • Medical history • Physical exam of pelvic organs including PAP test • Vaginal smear • Physical exam of the breasts • Rectal exam including FOBT • Consultation for birth control, if requested • Urinalysis	$0 copay/office visit	Not covered
Well-child care including routine examinations, blood lead level screenings, and immunizations	$0 copay/office visit	Not covered
Additional Newborn Examination *One newborn home visit during the first week of life if discharged less than 48 hours after a vaginal delivery or less than 96 hours after a cesarean-section delivery.*	$0 copay	Not covered
Routine immunizations – ordered by the provider and in accordance with national guidelines.	$0 copay *(Clinic visits for an allergy shot or immunization alone do not require a copay. If the visit is a combination of the injection and a nurse, primary care, or specialist visit, the required copay will be collected.)*	*Not covered*

* Each year members are allowed both an annual physical AND a well woman visit, both at the $0 copay.

Primary Care Pharmacy
303-602-8500
301 West 6th Avenue

Gipson Eastside Pharmacy
303-436-4600
501 28th Street

ID/HIV Clinic Pharmacy
303-602-8710
605 Bannock Street

La Casa/Quigg Pharmacy
303-602-8700
4545 Navajo Street

Montbello Pharmacy
303-602-4025
12600 Albrook Drive

Sandos Westside Pharmacy
303-436-4200
1100 Federal Blvd

You may take your prescriptions to any designated MedCare® (MedImpact) Pharmacy such as Albertsons, King Soopers, Safeway, Rite-Aid, Target, Walgreens, but your copay will be higher. You can find a pharmacy near you by visiting our website at www.denverhealthmedicalplan.com or by calling Member Services.

- **Formulary**

DHMP provides a list of covered drugs known as the Denver Health Managed Care Formulary. The formulary assists providers in selecting clinically appropriate and cost-effective drugs.

You can view the current formulary at www.denverhealthmedicalplan.com through the "Members" button or you can call Member Services to request a printed copy.

If a restriction is noted on the formulary or you do not see your drug listed, please talk to your provider. There may be a generic or a formulary approved alternative drug. Your provider may request an exception by calling or submitting a Prior Authorization Request (PAR) to the Managed Care Pharmacy Services Department. All requests are reviewed on a case-by-case basis.

- **Generic and Brand Copays**

You can save money by using generic drugs which have lower copays. Generic drugs are FDA-approved for safety and effectiveness and are manufactured using the same strict standards that apply to the brand name alternative. If you request a brand name drug when a generic is available, you must pay the higher, brand copay plus the difference in cost between the generic and brand name drug.

- **Refill Prescriptions**

It is best to call at least 3-5 days before you need your prescription. Your prescription is eligible for refill once 75% has been used. This is calculated using the original prescription directions. If the directions have changed please contact your pharmacy or provider for an updated prescription. If the prescription directions change or you need a refill earlier, please be sure to let your pharmacy know ahead of time. This will allow the pharmacy time get authorization if needed.

When you use Denver Health Pharmacies you may order your prescriptions using the automated refill line 1-866-DH-REFIL (866-347-3345) or by visiting www.denverhealthmedicalplan.com website.

- **Mail Order Pharmacy**

Another way to save time and money is by using a mail order pharmacy. You can have certain prescriptions delivered to your home and only pay 2 copays (instead of 3 copays) for a 90-day supply. Ask your provider to write the prescription for a 90-day supply so the pharmacy can fill the full amount.

Denver Health Pharmacy by Mail
Offers lower copays
Call Pharmacy Customer Service at:
303-602-2326 or toll free at 1-866-347-3345
Monday-Friday, 9 am - 5 pm
Prescriptions must be written by a DHMC provider

- **90-Day Supply at retail**

You will be able to purchase a 90-day supply for certain maintenance medications at designated Choice 90 pharmacies. You will pay 3 copays for each 90-day prescription. You can find out if your drug and/or pharmacy are included by visiting our website at www.denverhealthmedicalplan.com or by calling Member Services.

Preventive and Health Maintenance Medical Management

DHMP has developed clinical and preventive care guidelines and health management programs to assist members with common health conditions, including diabetes management, asthma, and pregnancy care. For information, please call 303-602-2100 or visit our website at: www.denverhealthmedicalplan.com. Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the following chart for your cost-sharing that may apply to preventive care services received by a Denver Health provider. Please keep in mind the following:

- You should consult with your physician to determine what is appropriate for you.
- When you see a specialist for preventive and health maintenance services, the specialist copay will apply except for a woman who wishes to see an obstetrician, gynecologist, or certified nurse midwife for her well-woman exam.

Prosthetic Devices

Prosthetic devices designed to replace an arm or a leg are covered. Repair and replacement of the prosthetic device is covered unless needed because of misuse or loss. NOT COVERED out-of-network.

External breast prostheses and mastectomy bras are covered following mastectomy. NOT COVERED out-of-network.

- **Artificial Eyes**

  Artificial eyes are covered. Artificial eyes will not be replaced if lost, stolen, or damaged.

  Limitations: Cleaning and repair of artificial eyes is not a covered benefit.

  In network: 20% of actual cost.
  No maximum benefit. Does not accrue towards $2500 yearly limit.

Radiology/X-Ray Diagnostic and Therapeutic Services

- **Radiology and X-Ray Services**

  All medically necessary radiology and x-ray tests, diagnostic services and materials prescribed by a licensed provider are covered, including diagnostic and therapeutic x-rays and isotopes. At Denver Health, mammograms can be scheduled at either the Radiology department or at the Women's Care van.

  In network: 20% after annual deductible is met

  Out-of-network: Not covered

- **MRI and PET Scans**

  In network: $150 copay

  Out-of-network: Not covered

- **Radiation Therapy**

  In network: 20% after annual deductible is met

  Out-of-network: Not covered

Rehabilitation Services/Therapies (Outpatient)

Physical therapy, occupational therapy and speech therapy will be authorized only until maximum medical improvement is reached or the annual benefit is exhausted, whichever comes first. However, early intervention services for children up to age 3 with developmental delays are covered without regard to maximum medical improvement. See "Early Intervention Services". In addition, medically necessary physical therapy, occupational therapy and speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to the age of six are covered even if the purpose of the therapy is to maintain functional capacity.

In network: $25 copay per visit.

Out-of-network: Not covered

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy. See "Early Intervention Services" for the benefit maximum for therapies for children to age three.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery - Outpatient. Examples of surgical

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

8.1 Non-Network Providers

Services provided by a hospital, pharmacy or other facility or by a physician, dentist, or other provider not participating in the DHMP Medical Care or the Cofinity networks are not covered unless:

- Provided under prior written referral by a participating PCP and prior authorized by the DHMP Medical Management department or
- Provided in an Emergency or urgent circumstance subject to the conditions described in Section 1 – Schedule of Benefits, and notification is made to the DHMP Medical Management department as soon as reasonably possible, preferably within 48 hours.

8.2 General Exclusions

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

- **Abortion**: Abortions past the 15th week, except when medically necessary.
- **Adaptive Equipment/Corrective Appliances**: Artificial aids; adaptation to telephone for the deaf; augmentative communication device; replacement of artificial eyes if lost, stolen or damaged; reading aids, vision enhancement devices; cochlear implants; penile implants; wheelchair ramps; home remodeling or installation of bathroom equipment; prosthetic devices (except for artificial limbs and breast prostheses); orthotics or braces for sports activities; braces for chronic conditions present for 3 months or longer (except braces for scoliosis); and experimental braces.
- **Ambulance Services**: Ambulance service for non-emergency care or transportation except as requested by DHMP.
- **Artificial Hair**: Wigs, artificial hairpieces, hair transplants or implants, even if there is a medical reason for hair loss.
- **Care Not Medically Necessary**: Any care not deemed medically necessary by a DHMP PCP, specialist, or the DHMP Medical Director.
- **Comfort and Convenience Items**: Personal comfort or convenience items or services obtained or rendered in or out of a hospital or other facility, such as television, telephone, guest meals, articles for personal hygiene, and any other similar incidental services and supplies.
- **Cosmetic and Reconstructive Surgery**: Elective cosmetic and reconstructive surgeries or procedures that are only performed to improve or preserve physical appearance.
- **Criminal Exclusions**: A medical treatment for accidental bodily injury or sickness resulting from or occurring during the member's commission of a crime, except for a crime defined under 18-18-102(5) C.R.S.
- **Dental Services**: Dental services; dental ancillary services; occlusal splints; overbite or underbite; osteotomies; TMJ (except as a result of trauma or fracture); hard or soft tissue surgery; maxillary, mandibular or other orthogenic conditions unless certified by a participating primary care practitioner (PCP) as medically necessary as a result of

trauma. See exceptions in Section 7 - Benefits/Coverage, Oral/Dental Surgery.

- **Disability/Insurance Physicals**: Coverage for physicals to determine or evaluate a member's health for enrollment in another insurance is excluded from coverage.
- **Durable Medical Equipment**: Rental or purchase of durable medical equipment except if medically necessary and prior authorized by the DHMP Medical Management Department. Humidifiers, air conditioners, exercise equipment, whirlpools, health spa or club are excluded whether or not prescribed by a physician. You are responsible for the entire cost of lost, stolen or damaged equipment (other than normal wear and tear).
- **Enzyme Infusions**: Therapies for chronic metabolic disorders.
- **Employment Exams**: Physical examinations for purposes of employment or employment-required annual examinations (e.g., D.O.T. exams) are excluded from coverage.
- **Excluded drugs and drug classes for the prescription drug benefit**: Anti-wrinkle agents, cosmetic hair removal products, dietary supplements (some are covered as consumable medical expenses), hair growth stimulants, immunization agents, blood or blood plasma, infertility medications, pigmenting/depigmenting agents, [nicotine-containing and OTC smoking deterrents (exception: some smoking cessation medications may be covered while participating in a DHMP class)], therapeutic devices/appliances (except certain diabetic testing supplies), charges for the administration/injection of any drug, prescription vitamins (except fluoride, folic acid, prenatal, vitamin B-12 and vitamin D), Over-the-counter (OTC) medications (except insulin and blood glucose testing supplies)..
- **Experimental Procedures and Drugs**: All experimental procedures and drugs as defined by the DHMP Medical Director. Drugs must be FDA approved to be considered non-experimental.
- **Extended Care**: Sanitarium, custodial or respite care (except as provided under Hospice Services), maintenance care, chronic care and private duty nursing.
- **Family Planning and Infertility**: Reversal of voluntarily induced infertility (sterilization); sex change operations; procedures considered to be experimental; in vitro fertilization; the Gamete Intrafallopian Transfer (GIFT); surrogate parents; drug therapy for infertility and the cost of services related to each of these procedures; the cost related to donor sperm (collection, preparation, storage etc.) for artificial insemination for members not currently receiving active treatment for infertility utilizing this assisted reproductive technology.
- **Formulary**: The Denver Health Medical Plan Formulary assists providers in selecting clinically appropriate and cost-effective medications for the Denver Health Medical Plan members. Notice of any additions to this list will be given in provider and member newsletters and our web site at www.denverhealthmedicalplan.com.
- **Governmental Facilities**: Services or items for which payment is made by or available from the federal or any state government or agency or subdivision of these entities; services or items for which a DHMP member has no legal obligation to pay.
- **Laboratory and Pathology Services**: Paternity testing; genetic testing to determine risk for developing cancer or chronic diseases; blood typing in the absence of transfusion.
- **Learning and Behavior Problems**: Special education, counseling, therapy or care for learning disabilities or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance.
- **Maternity Care**: Home deliveries; scheduled, non-medically necessary Cesarean sections; newborns of a dependent unless the newborn (grandchild) is the legal responsibility of the member; proof of court-ordered legal guardianship is required.
- **Medical Food**: Food products for cystic fibrosis or lactose or soy intolerance.
- **Neurostimulators**: Replacements or repairs, including batteries.
- **Obesity**: Commercial weight loss programs or exercise programs.
- **Ophthalmology**: Any costs for routine exams, eyewear, and for refractive LASIK surgery.
- **Optometric Vision Therapy/Treatment**: Individualized treatment regimen prescribed in order to provide medically necessary treatment for diagnosed visual dysfunctions, prevent the development of visual problems, or enhance visual performance to meet defined needs of the patient.

Optometric vision therapy includes visual conditions such as strabismus, amblyopia, accommodative dysfunctions, ocular motor dysfunctions, visual motor disorders, and visual perceptual (visual information processing) disorders.

- **Other Providers**: Services provided by acupuncturists, massage therapists, faith healers, palm readers, physiologists, naturopaths, reflexologists, rolfers, iridologists, or other alternative health practitioners.
- **Outpatient Psychiatric/Mental Health**: Psychological testing required by a third party; educational or occupational testing or counseling; vocational or religious counseling; developmental disorders such as reading, arithmetic, language or articulation disorders; IQ testing.
- **Over-the-Counter Drugs**: Over-the-counter drugs, nutritional supplements or diets, and over-the-counter medical supplies (except insulin and diabetic testing supplies). Vitamins, minerals or special diets, even if prescribed by a physician (except medical food for children with inherited enzymatic disorders) with the exception of the non over-the-counter prescriptive items such as electrolytes, certain vitamins and minerals which are listed in the Denver Health Medical Plan formulary.
- **Plastic Surgery**: Plastic surgery for cosmetic purposes; removal of tattoos and scars; chemical peels or skin abrasion for acne.
- **Private Duty Nurses**: Services of private duty nurses.
- **Residential Treatment**: Residential treatment facilities provide 24-hour care with counseling, therapy and trained staff.
- **Transplants**: Organ transplants except for: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome and lymphoma; donor-related expenses for donors who are members of DHMP who are donating to an individual who is not a DHMP member.
- **Vocational Rehabilitation**: Vocational rehabilitation, services related to screening exam or immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any other non-preventive purpose.
- **Work-Related Injury or Illness**: Charges for services and supplies (including Return to Work exams) resulting from a work-related illness or injury, including expenses resulting from occupational illnesses or accidents covered under workers' compensation, employers' liability, municipal, state or federal law or occupational disease laws except for members who are not required to maintain or be covered by workers' compensation insurance as defined by Colorado workers' compensation laws.

9 Member Payment Responsibility

9.1 About Your Medical Benefits

All services covered by DHMP must satisfy certain basic requirements. The services you seek must be medically necessary; you must use Denver Medical Care network providers; the services cannot exceed benefit maximums; and the services must be appropriate for the illness or injury. These requirements are commonly included in health benefit plans but are often not well understood or are simply overlooked. By communicating with your PCP and allowing your PCP to manage your care, these requirements will be met and will help to ensure that you receive medically necessary covered services.

9.2 Copayments

A copayment (or copay) is a predetermined amount, sometimes stated as a percentage and sometimes stated as a fixed dollar amount, that you are required to pay to receive a covered service. Copayments are paid directly by you to the provider. For applicable copayments, see the Summary of Benefits Form at the beginning of this chapter. You will be responsible for all expenses incurred for non-covered services. Copayments do not apply to your out of pocket maximum.

9.3 Annual Deductible

This is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. This amount will apply to your out of pocket maximum.

9.4 Per Occurrence Deductible

A per occurrence deductible is separate from the annual deductible and must be paid for each separate applicable services, including but not limited to services such as surgery or inpatient stays.

9.5 Coinsurance

The charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services after applicable deductibles are met. This amount will apply to your out of pocket maximum.

9.6 Out of Pocket Maximum

This is the maximum amount you pay every year. Deductibles and Coinsurance apply to the out of pocket maximum. However, copayments do not apply.

9.7 Benefit Maximums

Benefit maximums are the limits set by DHMP on the number of visits per calendar year, number of inpatient days per calendar year, or on the specific dollars paid by DHMP per calendar year.

10 Claims Procedure (How to File a Claim)

10.1 How to File a Claim

For Medical Service

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

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

There are situations in which you may need to file a claim for care you receive. If you receive emergency or urgent care from a provider outside of the Denver Medical Care network, you may be asked to pay the entire bill or a portion of the bill at the time of service. Eye wear and hearing aids may be purchased from any eye wear or hearing aid supplier. You may be required to pay the entire amount to the provider at the time of service. DHMP will reimburse you up to the limits noted in Section 7 - Summary of Benefits. If you are required to pay at the time of service, mail your receipt, including your name, home mailing address and member ID number to the following address:

Denver Health Medical Plan, Inc.
Attention: Claims Department
P.O. Box 40637
Denver, CO 80204-0637

To be reimbursed for eye wear and orthotics, please use the reimbursement form, Attachment D, at the end of this handbook. DHMP will mail a reimbursement check to the subscriber's home address, in the amount up to the benefit maximum. Claims submitted to DHMP later than 120 days after the date of service may be denied due to late filing.

For Pharmacy Service

Present your DHMP identification card at any MedImpact network pharmacy when you have your prescriptions filled. You are responsible for paying the pharmacy copayment. If you are out of the Denver Medical Care network Area and cannot locate a network pharmacy, please call the Member Services Department at 303-602-2100 or 800-700-8140 for information on how to get your prescription filled. If you pay the full cost for an eligible prescription medication, please mail your pharmacy receipt, along with your name, mailing address and member ID number, to the following address:

Denver Health Medical Plan, Inc.
Attention: Pharmacy Department
777 Bannock Street, Mail Code 6000
Denver, CO 80204

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

10.2 Claims Investigation

If you have questions or concerns about how a claim is settled, please call the Member Services Department at 303-602-2100 or 800-700-8140. If you disagree with the manner in which DHMP has settled a claim, or if you disagree with a denial of a claim payment, you may file a written or verbal grievance. See Attachment A at the back of the handbook for a copy of this form. You may also obtain a grievance form, or if you wish, give DHMP the details of your disagreement over the telephone by calling 303-602-2100 or 800-700-8140. You may also write to:

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

If you are appealing a claim that was denied due to lack of medical necessity or prior authorization, denial of prior authorization, or experimental status, please see Chapter 7 (Grievance and Appeal Process).

10.3 Claims Fraud

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policy-

holder or claimant with regard to a settlement or payment from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

10.4 Coordination Of Benefits

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and chose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits each group health plan to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first. Any plan that does not contain your state's coordination of benefits rules will always be primary.

When This Plan Is Primary

If you are a family member covered under another plan in addition to this one, we will be primary when:

Your Own Expense

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expense

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- Your Child's Expense
- The claim is for the health care expenses of a child covered by this plan and
- Your birthday is earlier in the year than your spouse's. This is known as the "birthday rule"; or
- You have informed us of a court decree that makes you responsible for the child health care expenses; or
- There is no court decree but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We are Secondary

We will be secondary whenever the rules do not require us to be primary.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part of all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayment and deductible.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.
- We will determine our payment by subtracting the amount the primary plan paid from the amount we should have paid if we had been primary. We will credit any savings to a "benefit reserve" that can be used to pay the balance of any unpaid allowable expenses covered by either plan.
- If the primary plan covers similar kinds of health care, but allows expenses we do not cover, we will pay for those items as long as you have a balance in your benefit reserve.

We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Coordination of benefits applies when you have automobile insurance with medical payment coverage. Medical payment coverage is always primary to this Plan when you are injured in an automobile accident. Medical payment coverage can also be used to pay any coinsurance or copayment amounts that you may be required to pay under this Plan.

10.5 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:

- The Denver Health Medical Plan, Inc. ("DHMP") may collect paid benefits directly from the liable party, the liable party's insurance company, and from any other person, business, or insurance company obligated to provide benefits or payments to you including your own insurance company if you have medical payment, uninsured, underinsured, or other coverage.
- You will tell DHMP, within 30 days of your becoming injured or ill:
- If another party caused your injury or illness.
- The names of the liable party and that party's insurance company.
- The name of your own insurance company if you have coverage for your injury or illness.
- The name of any lawyer that you hired to help you collect your claim from a liable party.
- You or your lawyer will notify the liable party's insurance company, and your own insurance company, that:

The DHMP is paying your medical bills.

The insurance company must contact DHMP to discuss payment to DHMP.

The insurance company must pay DHMP before it pays you or your lawyer.

- Neither you nor your lawyer will collect any money from an insurance company until after DHMP is paid in full. This applies even if the insurance money to be paid is referred to as damages for pain and suffering, lost wages, or other damages.
- If an insurance company pays you or your lawyer and not DHMP, you or your lawyer will pay the money over to DHMP up to the amount of benefits paid out. DHMP will not pay your lawyer any attorney's fees or costs for collecting the insurance money.
- DHMP will have an automatic subrogation lien, and direct right of reimbursement, against any insurance money that is owed to you by an insurance company, or that has been paid to your lawyer. DHMP may notify other parties of its lien and direct right of reimbursement.
- DHMP may give an insurance company and your lawyer any DHMP records necessary for collection. If asked, you agree to sign a release allowing DHMP records to be provided to an insurance company and your lawyer. If asked, you agree to sign any other papers that will help DHMP collect.
- You and your lawyer will give DHMP any information requested about your claim against the liable party.
- You and your lawyer will notify DHMP of any dealings with, or lawsuits against, the liable party.
- You and your lawyer will not do anything to hurt the ability of DHMP to collect paid benefits from the liable party or an insurance company.
- You will owe DHMP any money that DHMP is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMP any attorney's fees and costs that DHMP must pay in order to collect this money from you. If you or your lawyer do not help, or interfere with, DHMP in collecting paid benefits, then DHMP may contact the State of Colorado and request that you be disenrolled for cause from DHMP and placed in Medicaid fee-for-service.
- DHMP will not pay any medical bills that should have been paid by another party or insurance company.
- If you have questions, please call our Member Services Department at 303-602-2100.

10.6 Disclosure of Health and Billing Information to Third-Parties

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

10.7 Venue

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

11 General Policy Provisions/HIPAA

Effective April 14, 2003

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

At Denver Health Medical Plan, Inc. (DHMP), we respect the privacy of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

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

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

We are required to follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will mail a copy of the new notice to all subscribers covered by DHMP at that time.

How We Use or Share Information

- Federal law allows us to use or share protected health information for the purposes of treatment, payment, and health care operations without your authorization. The following are ways we may use or share information about you:
- We may use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment.
- We may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor.
- We may use or share your information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- We may share your existing drug profile with another prescribing provider in order to reduce drug interactons.
- We may use or share information for such health care operations as conducting quality assessment and improvement activities; care coordination or case management; and underwriting or premium rating.
- We may share your information with others who help us conduct our business operations. For example, consultants who provide legal, actuarial, or auditing services, or collection activities. We will not share your information with these outside groups unless they agree to keep it protected.
- We may share information with insurance companies and others who are obligated to pay your medical bills
- We may use or share your information for certain types of public health or disaster relief efforts.
- We may use or share your information to send you a reminder if you have an appointment with your doctor.
- We may use or share your information to give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we might send you information about smoking cessation or weight loss programs.
- We may use or share your information with the plan sponsor as necessary to carry out administrative functions of the plan. We will not share detailed health information with your health benefit plan sponsor.

There are also state and federal laws that may require DHMP to use or share your health information without your authorization as follows:

- We may provide information to a family member, friend, or other person, for the purpose of helping with your health care or with payment for your health care, if you are in a medical emergency and you cannot give your agreement to DHMP to do this.
- We may provide information to a personal representative designated by you or by law.
- We may report information to state and federal agencies that regulate us such as the US Department of Health and Human Services and the Colorado Division of Insurance, the Colorado Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing.
- We may share information for public health activities. For example, we may report information to the Food and Drug Administration for investigating or tracking of prescription drug and medical device problems.

- We may report information to public health agencies if we believe there is a serious health or safety threat.
- We may share information with a health oversight agency for certain oversight activities (for example, audits, inspections, licensure, and disciplinary actions).
- We may provide information to a court or administrative agency (for example, pursuant to a court order or search warrant).
- We may report information for law enforcement purposes.
- We may report information to a government authority regarding child abuse, neglect, or domestic violence.
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes, or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security, and intelligence activities, and the protective services for the President and others.
- We may report information on job-related injuries because of requirements of your state worker compensation laws.

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

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

What Are Your Rights

The following are your rights with respect to your health information. If you would like to exercise the following rights, please contact the DHMP Member Services Department by telephone at 303-602-2100 or 800-700-8140, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m., or by U.S. mail at 777 Bannock Street, Mail Code 6000, Denver, CO 80204.

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

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

You have the right to ask to receive confidential communications of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by telephone) or to an alternative address. We will accommodate a reasonable request if the normal method or disclosure could endanger you and you state that in your request. Any such request must be made in writing to the Member Services Department.

You have the right to inspect and obtain a copy of information that we maintain about you in your designated record set. A "designated record set" is a group of records that may include enrollment, payment, claims adjudication, and case or Medical Management department records.

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

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

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

You have the right to ask us to make changes to informa-

tion we maintain about you in your designated record set. These changes are known as amendments. Your request must be made in writing to the Member Services Department, and you must provide a reason for your request. We will respond to your request no later than 60 days after we receive it. If we are unable to act within 60 days, we may extend that time by no more than an additional 30 days. If we need to extend this time, we will notify you of the delay and the date by which we will complete action on your request.

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

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

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

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

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

You have a right to receive a copy of this notice upon request at any time. Requests for a copy of this notice should be directed to the Member Services Department.

Questions or Complaints

If you have any questions about this notice or about how we use or share information, please contact the DHMP Member Services Department at 303-602-2100 or 800-700-8140, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

You may also contact us by U.S. mail at 777 Bannock Street, Mail Code 6000, Denver, CO 80204.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting the DHMP Member Services Department at 303-602-2100 or 800-700-8140, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m.

12 Termination/Nonrenewal/Continuation

12.1 Continuation of Coverage Under Federal Law

This section provides general information about continuation of coverage under federal law known as COBRA (which stands for "Consolidated Omnibus Budget Reconciliation Act"). Under this law, you or your dependents may be able to continue as members of DHMP even though you or your dependents no longer qualify for coverage as an employee or eligible dependent. Your benefits will not change if you continue with DHMP under COBRA. Certain "qualifying events" may trigger eligibility for continuation of coverage under COBRA. They include:

Termination of Employment

If your employment terminates for any reason except gross misconduct, you may elect continuation coverage for yourself and your covered dependents.

Reduction in Hours Worked (Full-Time to Part-Time)

If your work hours are reduced, and as a result you become ineligible for employer paid health insurance, you may elect continuation coverage for yourself and your covered dependents.

Divorce, Legal Separation, or Death

If you and your spouse divorce or legally separate or if you should die, your covered spouse and your other covered dependents may elect continuation coverage for themselves.

Medicare Eligibility

If you become eligible for Medicare, and your eligibility results in the loss of coverage for your covered dependants, your covered spouse (if not entitled to Medicare) and other covered dependents may elect continuation coverage. Additionally, DHMP may be selected by you as a secondary payer under certain circumstances.

Loss of Eligibility

If your covered dependent child becomes ineligible for coverage under DHMP due to your employer's eligibility requirements, your covered dependent child may elect continuation coverage.

12.2 Notification Requirement

The table below outlines the responsibility of the employer, employee and DHMP in the event that an employee loses coverage.

Type	Employee	Employer	DHMP
Event		Notify employee of rights within 10 days of qualifying event	
Election	Notify employer within 60 days of receipt of employer notification of intent to continue coverage	Notify DHMP of employee's intent to continue coverage	DHMP will provide coverage to employee subject to conditions as set by law
Premium payment	Pay premium to employer within 45 days after electing coverage -Premium charge is 100% of total premium (from date of qualifying event) plus 2% administrative charge (disabled - 150% of premium)	Forward premiums to DHMP by the 1st of each covered month of benefits	DHMP will provide coverage to employee subject to conditions as set by law

12.3
Maximum Period Of Continuation Coverage

The maximum period of continuation coverage is dependent on the qualifying event. The table below briefly describes the maximum period of continuation coverage for each category of qualifying event.

Qualifying Event	Continuation Period	Qualified Beneficiaries
Termination of employment (except for gross misconduct) or reduction in work hours of the employer	18 months	Employee, covered spouse and covered dependents
Death of employee	36 months	Covered spouse, covered dependents
Divorce or legal separation of the employee from employee's spouse	36 months	Covered spouse, covered dependents
Medicare: employee becomes eligible for Medicare and that eligibility results in the loss of coverage for your covered dependents	36 months	Covered spouse, covered dependents
Non-dependent child: dependent child ceases to be a dependent child under the requirements of the DHMP	36 months	Covered dependent child
Social Security Administration determines that a qualified beneficiary was disabled at the time of the qualifying event or within the 60-day election period after the qualifying event (except when termination or reduction of working hours is due to gross misconduct).	29 months	Disabled beneficiary

Newborn or Adopted Children of Qualified Beneficiaries

Only you, by reason of having been an employee, and your child born or adopted during the continuation period, have an independent right to continue or change a coverage election during the continuation period. All other dependents are obligated to continue the coverage option chosen by the employee. However, you must enroll your new child (ren) as a dependent within 31 days of birth, adoption, and legal guardianship or new spouse as a result of marriage, in order to have this added protection. Any increase in premium due to this change must be paid during the period for which the coverage is in effect.

More Than One Qualifying Event

If an individual experiences more than one qualifying event, all qualified beneficiaries under the second qualifying event will be entitled to 36 months of continuation coverage, computed from the date of the first qualifying event.

Termination of Continuation Coverage

Continuation coverage will terminate, prior to the maximum period stated above, if:

- You or your dependent fail to make a premium payment within 30 days after the date it is due.
- You or your dependent become covered as an employee or otherwise under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition.
- You or your dependent become entitled to Medicare benefits.
- Your former employer no longer maintains any group health plan.

State Continuation Coverage

If the COBRA coverage described above does not apply (e.g. because you were terminated for gross misconduct), you and your eligible dependents may still be eligible for continuation coverage under state law if:

- your coverage was terminated for reasons other than discontinuation of a group plan in its entirety;
- you have been continuously covered under the group

plan for at least six (6) months immediately prior to the termination of your coverage; and

- you are not covered by Medicare or Medicaid.

Continuation coverage under state law is for a period of 18 months from the date of termination. The coverage will end before the exhaustion of the 18-month period if:

- you become eligible for other group coverage; if the new coverage excludes a condition covered by the continuation coverage, you may be covered by DHMP for that condition only for 18 months or until the new plan covers the condition, whichever occurs first.
- you fail to pay premiums when due.

Your employer will notify you of the right to continuation coverage under state law within 10 days of termination. You must notify your employer of your election of continuation coverage within 30 days after termination of employment.

12.4 Conversion Coverage

Eligibility for Conversion Coverage

Once continuation coverage has been exhausted (or if you are not eligible for continuation coverage), you and your covered dependents may obtain conversion coverage if the following conditions are met:

a) you have been continuously covered under the group plan for at least three months;

b) you make written application for conversion coverage to DHMP and pay the first month's premium to DHMP within 31 days after your continuation coverage expires;

c) you and your dependents are not covered by Medicare at the time of application; and

d) you and your dependents are not covered by or eligible for similar benefits under another group or individual plan, such that the other coverage, together with the converted policy, would result in over-insurance according to DHMP's standards.

Conversion coverage is individual, not group coverage. Conversion policies will be issued without any evidence of insurability. A basic and a standard plan are available. Call Member Services at 303-602-2100 or 1 800-700-8140 to find out more about conversion plans.

Notice of Conversion Right

Your employer will give you written notice of your right to convert to an individual conversion policy before the expiration of your continuation coverage. If you do not receive timely notice, you will have 15 days from the date of the notice received to elect conversion coverage.

Premium Payment

Premiums are determined by DHMP in accordance with its table of premium rates applicable to age and enrollment status (single vs. family, etc.). Premiums are paid directly to DHMP, with the first month's premium paid within 31 days after your coverage under the group plan expires.

When Conversion Coverage Becomes Effective

Conversion coverage becomes effective on the day following the expiration of your coverage under the group plan.

When Conversion Coverage Ends

Conversion coverage ends when:

a) you and your dependents are covered for similar benefits under another plan (individual or group); or

b) you and your dependents are eligible for similar benefits under any group plan;

c) the end of the last month for which premium is paid; or

d) you and your covered dependents voluntarily terminate your coverage; or

e) you or your covered spouse are covered by Medicare. The spouse not covered by Medicare and your other covered dependents may continue under the conversion policy.

13 Appeals and Complaints

13.1 The Difference Between Grievance and Appeal

As a member of DHMP, you have the right to voice Grievances. A Grievance is a written or oral request that the Plan investigate the quality of care you receive, the failure of a provider or the Plan to accommodate your needs, an unpleasant experience or any other service issue, including but not limited to the determinations of covered benefits. An Appeal is a written or oral request that the Plan review an adverse decision about requested medical service, care or treatment, e.g., the Plan's decision to deny prior authorization for a test, or to deny a particular type of treatment.

13.2 How to File a Grievance

You may file a Grievance by writing or calling the Grievance and Appeal Department at 303-602-2261 or the Member Services Department at 800-700-8140, TTY/TDD users should call 303-602-2129 or toll free at 1-866-538-5288 or you can put your Grievance in writing by completing **Attachment A at the end of your Member Handbook**. If you are unable to make the Grievance yourself, you may assign a person to act on your behalf, by completing the Designated Personal Representative (DPR) form. (**Please see Attachment C in your handbook**) Please mail your Grievance to the following address:

DHMP Complaint Coordinator
777 Bannock St., MC 6000
Denver, CO 80204-4507

The Grievance team will conduct an investigation and attempt to resolve the issue. You will be contacted regarding the resolution of your Grievance by letter within 20 business days of receipt of the Grievance. The letter will explain how your grievance was resolved. You have the right to contact the Colorado Division of Insurance if your concerns are not satisfactorily resolved by DHMP.

13.3 How to File an Appeal

If you have received a letter stating that the requested service, care or treatment is denied the decision is called an adverse determination and is subject to the Appeal process. Many adverse determinations involve the question of whether a requested service, care or treatment is medically necessary. Sometimes the question is whether the requested treatment is experimental or a covered benefit.

Your provider can start the Appeal review process by requesting a peer-to-peer conversation about the adverse determination by calling the DHMP Medical Management Department at 303-602-2140. In peer-to-peer conversation, your provider may talk with the DHMP reviewer who made the adverse determination. The conversation should occur within five calendar days of the request. If your provider wants to Appeal on your behalf please submit a copy of the Designated Personal Representative form signed by you and your provider. **Please use Attachment C at the end of this handbook.**

An Appeal is a written request from you to DHMP that your denied request for service, care or treatment be further reviewed. In conducting Appeals, DHMP follows the procedures mandated by the Colorado Division of Insurance. There are two levels of appeals. **You may use Attachment B, at the end of this handbook**, to submit a written request for an Appeal. An Appeal may be requested instead of a peer-to-peer conversation or following peer-to-peer conversation if the decision is once again adverse. The Appeal request must be received by DHMP within 180 calendar days after the date you received notice of the initial denial.

First Level Appeal Reviews

First level Appeal reviews are evaluated by a physician who consults with an appropriate clinical peer or peers who was not previously involved in the initial adverse determination. The physician and clinical peer(s) shall not have been involved in the initial adverse determination.

In conducting a review the reviewer or reviewers will take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person without regard to whether the information was submitted or considered in making the initial adverse determination. You will be notified of the decision in writing within 30 calendar days following the request for an appeal review. The notice letter will tell you the following: who performed the Appeal review, the reviewer's understanding of the request, the reviewer's decision in clear terms, the clinical rationale for the decision, any Handbook provision that applies, the guideline, criteria or other documents relied upon, the way to obtain a copy of any applicable guideline or criteria used, and how to file a voluntary second level Appeal review and external Appeal review.

Voluntary Second Level Appeal Reviews

If you are not satisfied with the first level Appeal review, you may request a second level review. Your request for a second level Appeal review must be in writing and filed within 30 calendar days of receipt of an adverse first level review decision. You can put your Voluntary Second Level Appeal in writing by completing Attachment B at the end of this Member Handbook. At the second level, your request for service, care or treatment

will be reviewed by a health care professional who was not involved in the previous denials and who does not have a direct financial interest in the Appeal or the outcome of the review.

The health care professional will have appropriate expertise in the type of care being reviewed. A review will be scheduled with the DHMP appeals Committee and held within 60 calendar days of receiving the request for a second level review. You will be notified in writing at least 20 calendar days in advance of the review date.

You may request a copy of the materials DHMP intends to present at the review; you must submit your request at least five days before the review. DHMP may also request a copy of all materials you intend to present at the review. You may present your case in person, in writing, through a representative, or by teleconference call and be assisted or represented by a person of your choice, including an attorney. You may ask questions of any DHMP representative prior to the hearing and the reviewer at the hearing; submit supporting material both before and at the review meeting. DHMP will make an audio or video recording of the review unless neither you nor DHMP wants the recording made. All comments, documents, records and other information about the request will be considered. The reviewer will send you a decision letter within seven calendar days of completing the review. The letter will include the name, title, and qualifying credentials of the reviewer; a statement of the reviewer's understanding of the nature of the Appeal review and all pertinent facts; a clear statement of the decision; the rationale for the reviewer's decision; the guideline, criteria or other documents relied upon; how to request a copy of all relevant documents mentioned above; and if the decision is adverse, how you can request an external review of your Appeal.

External Appeal Reviews

External review is available only for adverse decisions in the Appeal process where you have gone through at least one level of Appeal review. You or an authorized representative must send a written request for an external review to Member Services within 60 calendar days after you receive the result of your first or second level Appeal. External review is provided at no cost to you and is arranged by the Colorado Division of Insurance. The Division will assign an independent external review agency to perform a thorough review of your Appeal. You will receive a decision from the external review agency within 30 calendar days of its receipt of your request. Expedited external reviews are available if necessary.

Expedited Appeal Reviews

If the time frame of the standard review procedures set forth above, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or for the persons, with a physical or mental disability, create an imminent and substantial limitation on their existing ability to live independently, you may request an expedited review. Expedited Appeal reviews can also be requested if in the opinion of a physician with knowledge of the covered person's medical condition, would subject their covered person to severe pain that cannot be adequately managed without the health service, care or treatment that is subject of the request. A decision will be made and you and your provider will be notified as quickly as your medical condition requires, but not more than 72 hours after the review is started. Initial notification will be made by telephone or sent by facsimile and, written confirmation sent within two working days of notification, if the initial notification was by telephone. Expedited Appeal reviews request can be made orally or in writing.

13.4 The Division of Insurance

If you have concerns that are not satisfactorily resolved by DHMP, you have the right to contact the Colorado Division of Insurance. Write to:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202

13.5 As a Member of the Denver Health Medical Plan, Inc.

As a member in the Denver Health Medical Plan, Inc., you are entitled to certain rights under federal law.

Denver Health Medical Plan, Inc. Records

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

Confidentiality of Member Medical Records

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

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

To make a request, call Member Services at 303-602-2100 or 800-700-8140. Members also have the right to inspect and obtain copies of their medical records maintained by Denver Medical Care Network providers. Please contact the individual provider for more details.

Notice of Privacy Practices

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

The Denver Health Medical Plan Notice of Privacy Practices has been included at the end of this Member handbook for your review. A new notice will be provided of any material change in our practices. You may, at any time, obtain a copy of the notice by contacting Member Services at 303-602-2100 or by calling 800-700-8140.

Administration of Covered Benefits

Under federal law, individuals responsible for the operation of DHMP must perform their duties in a careful and conscientious manner, and with the interest of all members taken into consideration. DHMP and/or its agents will professionally and consistently strive to administer the Plan in accordance with this handbook, to the specific definitions of terms used (see Chapter 9 – Definitions of Terms) and applicable state and federal laws. DHMP will assist you in obtaining the benefits for which you are eligible. No one, including your employer, a union or any other person, may fire you or discriminate against you to prevent you from obtaining any benefit under this plan or exercising your rights under law.

Agreement to the Terms in Handbook

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

13.6 Your Rights and Responsibilities at Denver Health

Know what your rights and responsibilities are. Direct any questions, comments or problems to the DHMP Member Services Department at 303-602-2100 or 800-700-8140.

Member's Rights

- To be treated with courtesy, respect, and recognition of your dignity and right to privacy.
- To receive equal and fair treatment, without regard to race, religion, color, creed, national origin, age, sex, sexual preference, political party, disabillity, or participation in a publicly financed program.
- To know the names and titles of the doctors, nurses, and other persons who provice care or services for the member.
- To be told what your condition is and the recommended treatment, how your condition is expected to change, and what follow-up is needed.
- To participate with your provider in making decisions about your health care.
- To request or refuse treatment to the extent of the law and to know what the outcomes may be.
- To choose or change your PCP within the network of providers, to contact your PCP whenever a health problem is of concern to you and arrange for a second opinion if desired.
- To expect that your medical records and anything that you say to your provider will be treated confidentially and will not be released without your consent, except as required or allowed by law.

- To receive quality care and be informed of the DHMP Quality Improvement program.
- To receive information about DHMP, its services, its practitioners and providers and members' rights and responsibilities, as well as prompt notification of termination or other changes in benefits, services or the Denver Medical Care Network.
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- To express your opinion about DHMP or its providers to legislative bodies or the media without fear of losing health benefits.
- To receive an explanation of all consent forms or other papers DHMP or its providers ask you to sign; refuse to sign these forms until you understand them; refuse treatment and to understand the consequences of doing so; refuse to participate in research projects; cross out any part of a consent form that you do not want applied to your care; or to change your mind before undergoing a procedure for which you have already given consent.
- To instruct your providers about your wishes related to advance directives (such issues as durable power of attorney, living will or organ donation).
- To receive care at any time, 24 hours a day, 7 days a week, for emergency conditions and care within 48 hours for urgent conditions.
- To have interpreter services if you need them when getting your health care.
- To change enrollment during the times when rules and regulations allow you to make this choice.
- To have referral options that are not restricted to less than all providers in the network that are qualified to provide covered specialty services; applicable copays apply.
- To expect that referrals approved by the plan cannot be changed after Prior authorization or retrospectively denied except for fraud or abuse.
- Receive a standing referral, from a PCP to see a DHMP network specialty treatment center, for an illness or injury that requires ongoing care.
- To make recommendations regarding DHMP's Members' Rights and Responsibilities' policies.
- Complain about or appeal a decision concerning the Managed Care organization or the care provided and receive a reply according to the grievance/appeal process.

Member's Rights for Pregnancy and Special Needs:

- Receive family planning services from any licensed physician or clinic in the DHMP network.
- To go to any participating OB/GYN in the Denver Medical Care Network without getting a referral from your PCP.
- To see your current non-network provider for prenatal care, until after delivery of the baby if you become a member of DHMP during your second or third trimester. This is dependent upon the non-network provider agreeing to accept DHMP's arrangements.
- To continue to see your non-network doctor(s) or provider(s), when medically necessary, for up to 60 days after becoming a DHMP member. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)
- For DME, DHMP will authorize up to 75 days. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

Member's Responsibilities:

- To treat providers and their staff with courtesy, dignity and respect.
- To make and keep appointments, to be on time, call if you will be late or must cancel an appointment, and to have your DHMP identification card available at the time of service and pay for any charges for non-covered benefits.
- To report your symptoms and problems to your PCP and to ask questions, and take part in your health care.
- To learn about the procedure or treatment and to think about it before it is done.
- To think about the outcomes of refusing treatment that your PCP suggests.
- To get an authorization from your PCP before you see a Specialist.
- To follow plans and instructions for care that you have agreed upon with your provider.

- To provide, to the extent possible, correct and necessary information and records that DHMP and its providers need in order to provide care.
- To understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- To state your complaints and concerns in a civil and appropriate way.
- Learn and know about plan benefits (which services are covered and non-covered) and to contact a DHMP Membership Services Representative with any questions.

Inform providers or a representative from DHMP when not pleased with care or service.

ADDITIONAL INFORMATION

Relationship between DHMP and Network Providers

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

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

Statement of Appropriate Care

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

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

If you feel that a DHMP representative or network provider has violated any of the above principles, you can contact the Member Services department at 303-602-2100 or 800-700-8140.

Conformity with State Law

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

Amendment or Termination of this Plan

This Plan can be modified by DHMP to change benefits only after notice to a subscribing group, unless the modification is required by a change in law.

Quality Improvement Program

DHMP continually strives to improve the quality of care and service to our members by ongoing monitoring of services. DHMP's Quality Improvement Program monitors and measures the level and quality of service and care, monitors compliance with certain preventive health measures, identifies opportunities to improve patient care, and resolves identified problems through appropriate intervention and education.

Some of the types of care that are measured and monitored on at least an annual basis include:

- Mammography and cervical cancer screening rates
- Childhood immunization rates
- Smoking cessation advice
- Treatment of asthma and diabetes
- Outpatient follow-up after an admission for a mental illness
- Referral turnaround time
- Member satisfaction with services and providers

Details of specific measurements can be found in the member newsletter from time to time. As a member of DHMP, you may request additional information regarding the Quality Improvement Program by calling Member Services at 303-602-2100.

14 Information on Policy and Rate Changes

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

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

15 Definitions

A Recommendation - means a recommendation adopted by the Task Force that strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

B Recommendation - means a recommendation adopted by the Task Force that recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

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

Adverse Determination: determination by the DHMP plan that request for benefit has been reviewed and based upon the information provided does not meet the plan requirement for medical necessity or is determined to be experimental or investigational, and is therefore denied, reduced, or terminated.

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

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

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

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

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

Clinical Trial - an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

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

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

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

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

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

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

Denver Medical Care Network: The Denver Health and Hospital Authority and the Denver Health and Hospital Authority providers located on the Denver Health and Hospital Authority campus, Denver Health and Hospital Authority neighborhood health care facilities that are conveniently located throughout the Denver metropolitan area and a members-only medical clinic, located on the Denver Health and Hospital Authority campus.

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

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

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

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

Durable Medical Equipment: Medical equipment that can withstand repeated use is not disposable and is used to serve a medical purpose in the treatment of an active illness or injury. Durable medical equipment is owned or rented to facilitate treatment and/or rehabilitation.

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

Emergency Medical Condition: The sudden and unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, would place the person's health in serious jeopardy.

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

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

General Hospital: A health institution planned, organized, operated, and maintained to offer facilities, beds, and services over a continuous period exceeding 24 hours to individuals requiring diagnosis and treatment for illness, injury, deformity, abnormality, or pregnancy. Clinical laboratory, diagnostic x-ray, and definitive medical treatment under an organized medical staff are provided within the institution. Treatment facilities for emergency and surgical services are provided either within the institution or by contractual agreement for those services with another licensed hospital. Services provided by contractual agreement are documented by a well-defined plan for the provision of contracted services, related to community needs. Definitive medical treatment may include obstetrics, pediatrics, psychiatry, physical medicine and rehabilitation, radiation therapy, and similar specialized treatment.

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

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder. Grievance: An oral or written statement by a provider, member or member's representative that expresses dissatisfaction with some aspect of DHMP service or administration.

Health Care Provider: Physician, practitioner, hospital, home health care agency, hospice or other specialized treatment facility that provides health care services. A health care provider can be either an individual or an organization.

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

(1) has policies established by a group of professional personnel associated with the agency or organization including policies to govern which services the agency will provide,

(2) maintains medical records of all patients, and

(3) is certified or accredited.

Hospice Care: An alternative way of caring for terminally ill individuals that stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the patient. Hospice

services include but are not necessarily limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

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

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

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

Medically Necessary (Medical Necessity): Appropriate and necessary services as determined by your PCP, specialist or the DHMP Medical Director, that are provided to a member according to accepted principles of good medical practice, for diagnosis or direct care and treatment of an illness or injury and are not provided only as a convenience.

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

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

Network Area: The counties of Denver, Arapahoe, Jefferson and Adams.

Network Provider: A health care provider who is contracted to be a provider in the Denver Medical Care Network.

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

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

Observation Stay: A hospitalization lasting 23 hours or less.

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

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

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

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

Primary Care Practitioner (PCP): The practitioner (physician, nurse practitioner or physician's assistant) that you choose from the Denver Medical Care Network to supervise, coordinate and provide initial and basic care to you. The PCP initiates referrals for specialist care and maintains continuity of patient care (usually a physician practicing internal medicine, family practice or pediatrics).

Prior authorization: authorization prior to receiving a specific service, treatment or care. Prior authorization must be requested by your primary care provider who needs to send the request along with medical necessity information.

Problems of Living: Stress-related conditions for which marital and couples counseling and family therapy are covered.

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

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

For Enrollment: any event that permits an individual to enroll outside open enrollment or initial eligibility periods (e.g., marriage, birth, adoption placement, divorce, legal separation, loss of dependent status).

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

Retirees: Subscribers who qualify for coverage under the Plan after retiring from an employer group.

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

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

(1) permanent and full-time facilities for ten or more resident patients;

(2) a full-time registered nurse or physician in charge of patient care;

(3) at least one registered nurse or licensed practical nurse on duty at all times;

(4) a daily medical record for each patient;

(5) transfer arrangements with a hospital;

(6) and a utilization review plan.

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

Standing Referral: Referral from PCP to a network specialist or specialty treatment center in the Denver Medical Care Network for illness or injury that requires ongoing care.

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

Subscriber: The employee whose employment is the basis for eligibility for enrollment in DHMP.

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

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

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

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

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ATTACHMENT A
Denver Health Medical Plan

Member Grievance Form

Member's Name _____Member's Date of Birth_____

Member's ID Number _____ Member's Medical Records #

Name of Member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

_____

_____

_____

Date of Incident _____

Contact Phone Number_____

Person(s) or Provider(s) involved _____

_____

Describe what happened _____

_____

_____

_____

_____

Signature of Member/DPR/Guardian _____
Date _____

Please send to: **Denver Health Medical Plan**
Attn: Complaints Coordinator
777 Bannock St., MC 6000
Denver, CO 80204-0606
Phone: 303-602-2261

Form No.: COM_MF_103-00
Creation/Rev Date 12/31/12

CONFIDENTIAL

ATTACHMENT B
Denver Health Medical Plan

Member Appeal Form

Member's Name _____Member's Date of Birth_____

Member's ID Number _____ Member's Medical Records #

Name of Member's Designated Personal Representative/Guardian
(please see DPR form/Attachment C at the end of the handbook)

_____

_____

_____

Date of initial denial letter_____

What was denied? _____

Reason for the denial (as noted in the letter) _____

Describe any new information since the initial review of this matter_____

_____

_____

_____

_____

Signature of Member/DPR/Guardian _____

Date _____

Please send to: **Denver Health Medical Plan**
Attn: Complaints Coordinator
777 Bannock St., MC 6000
Denver, CO 80204-0606
Phone: 303-602-2261

** To request an appeal of a decision regarding an adverse determination, this form must be submitted within 180 calendar days.

** If your initial request was denied as a non covered benefit, you need to provide additional medical evidence from your provider explaining why benefit exclusion should not apply in this case.

CONFIDENTIAL

ATTACHMENT C
Denver Health Medical Plan
Designation of Personal Representative

I, _____ (PRINT name of client), name and appoint

_____ (PRINT name of representative), to serve as my Designated Personal Representative.

I understand that my Designated Personal Representative will have access to information about me that is created by or on behalf of the Denver Health Medical Plan, and that this information can include Protected Health Information. My Designated Personal Representative is to be provided information about me, on my behalf, in order to assist me as I request of him/her.

This designation of a personal representative is being made in order that the designated individual act on my behalf in:

____ All actions required of me in my relationship with the Denver Health Medical Plan; *or*

____ Actions required of me in relation to the following specific purpose (check one that applies):

❑ Grievance ❑ Appeal _____ ❑ Other (please specify) _____

I understand that my Designated Personal Representative may disclose my information to a third party, and that the State Department has no control over that additional disclosure and can not protect the information after it is provided to my Designated Personal Representative.

I understand that I may revoke this Designation at any time by writing to the address below, and that this Designation will not expire unless and until I actively revoke it.

I understand that my health care treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating a Designated Personal Representative.

I understand this executed form does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions or treatment or psychotherapy notes, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.

Client signature: _____ **Date:** _____
Parent or Legal Guardian may sign on behalf of minor child.
Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult – documentation is required.

Client Date of Birth: _____

State ID #, Client ID #, or Member ID #: _____ *Used for identity verification purposes only*

Designated Personal Representative signature: _____

Designated Personal Representative relationship to Client: _____

Designated Personal Representative phone number: _____

Return Completed Form To: **Denver Health Medical Plan Inc.**
Attn.: Complaints Coordinator
777 Bannock Street, MC6000
Denver, CO 80204
Phone: 303-602-2261 • Fax: 303-602-2094

ATTACHMENT D
Denver Health Medical Plan

Authorization to Disclose Protected Health Information

I _____ , authorize Denver Health Medical Plan, Inc. ("DHMP"), and its attorneys and agents to release medical billing, medical claims, and health information regarding DHMP Member:

Member's Full Legal Name: _____

Member's Plan I.D. number:_____ **Member's Date of Birth:** _____

to the following:

Facility/Office/Company/Person_____

Address_____

City _____State

Zip Code_____

This disclosure is related to (check all that apply)

____ all claims with dates of service between _____ and _____

____ limited to claims with dates of service related to an accident/incident occurring on or about _____.

____ other records or limitations (please specify) _____

The purpose of this disclosure is to permit DHMP and its attorneys and agents to collect payment for my medical expenses from responsible third parties and/or to use such information in legal proceedings relating to payment for my medical care.

Other purpose (if applicable)_____

I understand by signing this form I have given my permission to release confidential medical and insurance billing information related to my medical claims, medical billing and medical care and treatment, which may include the following:

Diagnosis and/or treatment relating to mental health conditions, sexually transmitted diseases, and/or HIV/AIDS, unless restricted as follows _____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE

I understand I have a right to revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will automatically expire one (1) year from the date of signature. DHMP may not condition payment, eligibility or receipt of benefits upon the signing of this form; however, the information requested may be necessary for the payment of my medical bills or the operations of DHMP in accordance with applicable law. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality laws (HIPAA).

A copy or facsimile of this authorization is as valid as the original. If I have questions about disclosure of my health information, I can contact DHMP Member Services at 303-602-2100.

Signature of Member or Legal Representative_____

Date of signature _____

Relationship of Legal Representative (Mother, Father, Guardian) _____

Please complete this form, sign, and fax to Denver Health Medical Plan, Inc. at 303-602-2094.

Form No.: COM_MF_106-00
Creation/Rev Date 12/31/12

ATTACHMENT E
Denver Health Medical Plan, Inc.

2013
Member Reimbursement Form (CSA/DERP/DPPA)

Member's Name: _____

Mailing Address:_____

Member's I.D. Number: _____

JENNY CRAIG:

_____ S9449 25% monthly program reimbursement up to $150/month

ORTHOTICS:

_____ L3000 $50.00
Maximum benefit per calendar year

HEARING AID:

_____ V5100 $1500.00 every 5 years, if 18 years of age or older

Please NOTE: All necessary receipts must be submitted with reimbursement request.

Mail Claims to: **Denver Health Medical Plan**
Attn: Claims Department
P.O. Box 262269
Plano, TX 75026

Form No.: COM_MF_107-00
Creation/Rev Date 12/31/12

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.com. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Denver Health Medical Plan, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.com.
The lifetime limit on the dollar value of benefits under Denver Health Medical Plan, Inc. no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Denver Health and Hospital Authority Employee Benefits at 303-602-7000.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Denver Health Medical Plan, Inc. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1, 2012. For more information contact Denver Health and Hospital Authority Employee Benefits at 303-602-7000.

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

All Denver Health Medical Plan, Inc. enrollees have the option of calling the local prehospital emergency medical service system by dialing the emergency telephone access number 9-1-1 whenever an enrollee is confronted with a life- or limb-threatening emergency.

777 Bannock St., MC 6000
Denver, CO 80204
Member Services: 303-602-2100
www.denverhealthmedicalplan.com

Form No. COM_MKT_161-00
Created on 1/8/13

EXHIBIT 2
To Denver Health Medical Plan, Inc. Service Agreement

PERFORMANCE STANDARDS FOR HEALTH BENEFITS

PERFORMANCE STANDARDS FOR HEALTH BENEFITS

(a) Adjustment to Standard Service Fees

DHMP will present the City and County of Denver with premium credits on a quarterly basis when the specified performance levels are not attained as set forth in this Exhibit. The quarterly measurement report needs to be presented within 30 days following end of quarter with the premium credits due within 60 days of the end of each quarter. Unless otherwise specified, these standards are effective for the period beginning January 1, 2013 and ending on December 31, 2013.

(b) Administrative/Implementation Performance Standards

(i) ID Cards

For Open Enrollment, DHMP will mail 99% of the ID cards no later than 10 business days prior to the end of the year, subject to the final member eligibility data being transmitted to DHMP in the form requested by DHMP and subject to the eligibility file being both data complete and error free. See *Eligibility Loading* section of this document.

For subsequent enrollment, DHMP will mail 99% of ID cards within 10 business days of the eligibility data being transmitted to DHMP, in the form requested by DHMP, subject to the eligibility file being both data complete and error free. See Eligibility Loading section of this document.

Failure to maintain a ninety-nine percent (99%) score for each quarter will result in a credit to the quarterly premiums of 0.01% per quarter.

(ii) Eligibility Loading

DHMP will load implementation medical eligibility files within 3 business days of receipt. The guarantee is waived for files that cannot be loaded due to data errors, (e.g. incorrect addresses, incorrect social security numbers, missing dependent information, omitted members for enrollment) or for files that require reformatting of data but only if the data is in a format other than requested by DHMP. DHMP will notify the appropriate CSA representative immediately if file cannot be loaded due to any of the above reasons.

CSA will provide enrollment information on a weekly basis for automated processing. The files will contain information on all enrollees, including dependents. It will identify each enrollee's effective date, demographic data, and medical plan choice. Electronic information will also be provided on terminating enrollees, including dependents. The termination information will include termination dates. Termination information may be included in the same file with current enrollees or it may be provided in a separate file but all files must be sent with the same frequencies and be provided together.

Failure to load medical eligibility files into the eligibility system(s) within 3 business days will result in a credit of premiums of 0.01% for the quarter reported.

(c) Claim Operations Performance Standards

For the following "Claim Operations Performance Guarantees," the term "claim" shall mean a written request for payment of a Plan benefit made by a member or provider.

(i) Time to Pay

DHMP complies with, and will continue to be in compliance with, Colorado Law HB 99-1250 and CRS 10- 16- 106.5, which states health carriers must pay "clean" claims within 30 days if submitted electronically and 45 days if otherwise submitted.

DHMP will pay, or, if no monies are due, process ninety percent (90%) of all claims within 30 days of receipt for electronic claims and within 45 days of receipt for paper claims, as evidenced by a date stamp. Timeliness will be measured within a "Time to Pay" report produced on a monthly basis and provided to the City and County of Denver on a quarterly basis.

Failure to maintain a ninety percent (90%) score for the Time to Pay Guarantee will result in a credit to the quarterly premiums of 0.01% per quarter

(ii) Financial Accuracy

DHMP will maintain a Financial Accuracy rate of not less than ninety-nine percent (99%) for each quarter. Financial Accuracy is measured by collecting a statistically significant random sample of claims processed by the offices servicing the City and County of Denver account. The sample is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars submitted for payment. The measurement will be done by the carrier's standard internal quality assurance program based on a quarterly audit of claims processed.

Failure to maintain a ninety-nine percent (99%) score for Financial Accuracy for each quarter will result in a credit to the quarterly premiums of 0.01% per quarter

(iii) Procedural Accuracy

DHMP will maintain a Procedural Accuracy rate of not less than ninety-five percent (95%) each quarter. Procedural Accuracy is measured by collecting a statistically significant random sample of claims processed by the offices servicing the City and County of Denver account. The sample is reviewed to determine the percentage of claims processed without non-financial errors. Failure to maintain a ninety-five percent (95%) score in Procedural Accuracy for each quarter will result in a credit to the quarterly premiums of 0.01% per quarter.

(iv) Items Excluded from Claim Operations Performance Measurements

With some products (e.g. HMO), financial reimbursement arrangements are contractually negotiated with providers (physicians, labs, etc.), which budget the payment they receive for

certain services. Periodic payments are made to the providers in return for their agreement to provide the negotiated services to network members. Services provided under these arrangements are not processed as a typical "claim" and, as a result, results from the networks featuring these arrangements are not included in the performance statistics outlined above.

(d) Member Phone Service Performance Standards

(i) Average Speed to Answer

This standard applies to the Member Services office which provides service for the City and County of Denver employees. The Average Speed to Answer will be measured by the standard tracking reports produced by the automated phone system on a quarterly basis for all the calls handled by the office servicing your account.

Failure to maintain an Average Speed to Answer equal to or less than 30 seconds will result in a credit to the quarterly premiums of 0.01% per quarter This average speed to answer quarterly report will be based on the monthly ASA score averages.

Abandonment Rate

This standard applies to the Member Services office, which provides service for the City and County of Denver employees. DHMP will guarantee that calls will sequence through the automated telephone call distribution system such that no more than 5% of calls will be abandoned. The Abandonment Rate results will be measured quarterly by the standard tracking reports produced by the automated phone system for all calls handled by the Member Services office servicing the City and County of Denver account.

Failure to maintain an Abandonment Rate equal to or less than five percent (5%) for all locations providing member phone service to the City and County of Denver employees, will result in a credit to the premiums of 0.01% for the quarter reported.

(e) Health Risk Assessment (HRA) Performance Standards

The HRA will be available on the DHMP website. DHMP will send a list of employees who complete the HRA as part of the quarterly report. The list will be verified that it is composed of active plan members with the list being 95% accurate.

Failure to meet this standard will result in a credit to the premiums of 0.01% for the quarter reported.

(f) HEDIS Quality Score (Effectiveness of Care)

DHMP will maintain a score on the following 10 HEDIS* categories that is greater or equal to the national HMO published averages at the 50th percentile or a 3% increase compared to the previous year.

- Adult BMI Assessment

- Comprehensive Diabetes Care (blood pressure: <140/80)
- Comprehensive Diabetes Care (blood pressure: <140/90)
- Childhood Immunization Status – Combo 2
- Childhood Immunization Status – Combo 3
- Child BMI (3-11 years and 12-17 years)
- Child counseling for nutrition (total: 3-11 years and 12-17 years)
- Child counseling for physical activity (total: 3-11 years and 12-17 years)
- Appropriate treatment of Children with URI
- Appropriate Testing of Pharyngitis

*DHMP will report on those measures that have a statistically significant sample size of >30.

DHMP agrees to provide the City and County of Denver with all of the above HEDIS results. Failure of DHMP to meet or better the National HMO published averages at the 50th percentile or a 3% increase compared to the previous year on the best 9 out of the 10 indicators will result in a credit to the of 0.01% per for the quarter reported.

(g) Member Satisfaction Performance Standard

DHMP will conduct the NCQA CAHPS Adult Survey 5.0 annually.

CAHPS:

1. Q13: Have a personal doctor
2. Q21: Rating of personal doctor
3. Q23: Easy to get appointment with specialist
4. Q35: Got information or help needed
5. Q36: Treated you with courtesy and respect
6. Q37/38: Health plan forms easy to fill out
7. Q42: Overall rating of health plan based on 0-10 with 10 being the highest
8. Q44: % of respondents who responded "yes" to the question: had a flu shot since September?
9. Composite Measure: Customer service

In the event that DHMP falls below the NCQA Quality Compass Mean on any of the above on the best six (6) survey questions out of 9, a credit to the quarterly premiums of 0.01% per question, for the quarter reported will be made.

EXHIBIT 3
To Denver Health Medical Plan, Inc. Service Agreement

ACORD CERTIFICATE OF LIABILITY INSURANCE

OP ID: RL

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 11/16/12

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Kahl Insurance Services Arthur J. Gallagher & Co 6399 S Fiddlers Green Cir #200 Greenwood Village, CO 80111 Steven Kahl 720-489-7189 720-489-7190	CONTACT NAME: Deb Mc Comic PHONE (A/C, No, Ext): 303-889-2626 FAX (A/C, No): E-MAIL ADDRESS: Deb_mccomic@ajg.com PRODUCER CUSTOMER ID #: DENVE-1
INSURED Denver Health and Hospital Authority 660 Bannock Street, 5th Floor Denver, CO 80204-4507	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Lexington Insurance Company INSURER B : Safety National Casualty Corp. INSURER C : AMERICAN GUARANTEE & LIABILITY INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR X Professional Liab X Claims Made GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC			679-5055 RETRO DATE 01/01/97	01/01/13	01/01/14	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG Retention	$ $ $ $ $ $ $	1,000,000 1,000,000 3,000,000 1,000,000 250,000
A	AUTOMOBILE LIABILITY ANY AUTO X ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS X NON-OWNED AUTOS X 150,000			EXCESS/RETAINED AMT 47082778	01/01/13 01/01/13	01/01/14 01/01/14	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident) 	$ $ $ $ $ $	1,000,000
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DEDUCTIBLE RETENTION $			N/A			EACH OCCURRENCE AGGREGATE 	$ $ $ $	
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		SP4045285 EXCESS POLICY $600,000 SIR	01/01/13	01/01/14	X WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $	1,000,000 1,000,000 1,000,000
C	Property Boiler/Machinery			ZMD554296100 NO CO-INSURANCE	01/01/13	01/01/14	Limit Deduct.		750,000,000 50,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Evidence of Insurance

CERTIFICATE HOLDER

DENVERH

Denver Health & Hospital Authority
660 Bannock St, 5th Fl
Denver, CO 80204

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Steven E. Kahl