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); DPPAPLANA, MCRDPPA (Active police employees with Medicare primary due to ESRD/disability), DPPA COBRA, DPPA Retirees

Delegation of Signature Authority

The City authorizes the Executive Director of the Office of Human Resources, or the Executive Director's delegate, to sign any documents, rate sheets, or related documents necessary to implement this agreement.

(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, 2014, ("**Effective Date**") and shall remain in effect until 11:59 p.m., Denver time on December 31, 2014, 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, 2014.

(c) Copayment Schedule Edition Date: January 1, 2014.

(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, $1,000,000 products and completed operations aggregate, and $1,000,000 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, 2014 through and including December 31, 2014, shall not exceed FOUR MILLION SIX HUNDRED FIFTY THOUSAND AND NO/100 DOLLARS ($4,650,000.00), 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 (seewww.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 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-201417752-00

Contractor Name: Denver Health Medical Plan, Inc.

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

2014 HMO rates

Denver Health Medical Plan, Inc. Rates for Calendar Year 2014 Approved by the Colorado Division of Insurance	
Employee	$538.81
Employee & Spouse	$1,123.01
Employee & Child(ren)	$870.88
Employee and Family	$1,557.17

2014 Deductible HMO rates

Denver Health Medical Plan, Inc. Rates for Calendar Year 2014 Approved by the Colorado Division of Insurance	
Employee	$419.70
Employee & Spouse	$874.77
Employee & Child(ren)	$678.37
Employee and Family	$1,212.95

EXHIBIT 1

To agreement with
Denver Health Medical Plan, Inc.

INSURANCE POLICY HANDBOOKS

2013 Colorado Health Benefit Plan Description Form
Denver Health Medical Plan, Inc.
Denver Health Medical Care
CSA and DERP Non-Medicare Primary

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

IMPORTANT NOTE: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the Member Handbook, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the Member Handbook to determine the exact terms and conditions of coverage. Copayment options reflect the amount the covered person will pay.

	In Network	Out-of- Network
4. DEDUCTIBLE TYPE[2]	No deductible applies	No deductible applies
4A. DEDUCTIBLE[2a] **a) [Individual] [Single][2b]** **b) [Family] [Non-single][2c]**	 a) No deductible applies b) No deductible applies	No deductible applies
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **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) No out-of-pocket maximum	Not covered
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	Not covered
7A. 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
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes.	Not applicable
8. MEDICAL OFFICE VISITS/ SERVICES[4] **a) Primary Care Providers** **b) Specialists**	 a) $25 copay b) $40 copay	Not covered

	In Network	Out-of-Network
9. PREVENTIVE CARE SERVICES **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 • $0 colonoscopy/sigmoidoscopy • $0 annual screening mammography • $0 copay also includes all items on USPSTF preventive list • Immunizations: No cost for injection only; if part of an office visit, office visit copay will applyection only; if part of an office visit, office visit copay will apply	Not covered
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	a) $25 copay per visit b) $300 copay per admission	Not covered
11. PRESCRIPTION DRUGS[6] 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-formulary 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-formulary 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-formulary drugs (PA) 30-day supply): Discount: $16 copay Tier 1: $40 copay Tier 2: $60 copay for brand name drugs Tier 3: $120 copay for non-formulary drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
12. INPATIENT HOSPITAL	$500 copay per admission Pre-authorization required	Not covered

	In Network	Out-of-Network
13. OUTPATIENT/ AMBULATORY SURGERY	$200 copay Pre-authorization required	Not covered
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI and PET scans**	 a) 100% covered b) $200 copay	Not covered
14A. 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 (excluding immunizations, allergy shots and any other injection given by a nurse) e) Covered at 100%	Not covered
15. EMERGENCY CARE[7, 8]	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)
15A. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
16. AMBULANCE	$450 copay per trip (not waived if admitted)	$450 copay per trip (not waived if admitted)
17. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$50 copay per visit	$50 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit	Not covered
19. 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
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 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
21. 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
22. DURABLE MEDICAL EQUIPMENT	Plan pays 70%; maximum benefit is $2,000 per calendar year, pre-authorization required.	Not covered
22A. HEARING AIDS	Medically necessary hearing aids prescribed by a DHMP Medical Care Network Provider are covered every five years in network. For adults age 18 and over, there is a $1,000 benefit maximum every 5 years. Charges exceeding the $1000 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
22B. PROSTHETICS	Plan pays 70%. No maximum benefit, does not apply to annual DME limit.	Not covered
22C. 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.	
23. OXYGEN	100% covered; Equipment: 30% coinsurance, does not apply to DME maximum.	Not covered
24. 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
25. HOME HEALTH CARE	100% covered. Pre-authorization required.	Not covered
26. HOSPICE CARE	100% covered. Pre-authorization required.	Not covered
27. SKILLED NURSING FACILITY CARE	100% covered. Maximum benefit is 100 days per calendar year at authorized facility. Pre-authorization required.	Not covered
28. DENTAL CARE	Not covered except for fluoride varnish at PCP visit for children.	Not covered

	In Network	Out-of-Network
29. 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
30. 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
31. 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. Oral contraceptives are $0 copay both in and out of Denver Health. FDA-approved birth control devices $0 cost sharing. • **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

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions available immediately upon request or see Section 4 in the Member Handbook. Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	In Network	Out-of-Network
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
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	
39. What is the main customer service number?	303-602-2100 or 800-700-8140	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	DHMP-Member Complaint Coordinator 777 Bannock St., MC 6000 Denver, CO 80204 303-602-2100 or 800-700-8140	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202 E-mail: Insurance@dora.state.co.us Fax: 303-894-7455	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	COM_MKT_101-00	
43. Does the plan have a binding arbitration clause?	No	

Endnotes

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

2 "Deductible type" indicates whether the Deductible period is "Calendar Year" (Jan 1 – Dec 31) or "Benefit Year" (i.e. based on a benefit year beginning on the policy's anniversary date) or if the Deductible is based on other requirements such as "Per Accident or Injury" or "Per Confinement."

2A A "Deductible" means the amount that you will have to pay for the allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

2B "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

2C "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA-qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any benefits are paid.

3 "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

4 Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness and mental disorders as defined in Endnote number 9 below.

5 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments, unless mother and baby are discharged separately.

6 Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

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

8 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific 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.

10 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

11 Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of these procedures.

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.

DENVER HEALTH Medical Plan, Inc.

Career Service Authority / Denver Employee Retirement Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the costs of covered services.
What is not included in the out–of–pocket limit?	The plan has no **out-of-pocket limit**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Form No.: COM_MKT_127-00
Creation/Rev Date 12/26/12

OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$40 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$20 copay per visit for chiropractor	Not covered	$20/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$200 copay per test	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	Discount Generic (30 day supply) Denver Health Pharmacy $4 copay Non Denver Health Pharmacy $8 copay Generic (30 day supply) Denver Health Pharmacy $10 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $15 copay Non Denver Health Pharmacy (30 day) $30 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	Not applicable	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay	waived if admitted
	Emergency medical transportation	$450 copay per trip	$450 copay per trip	-------none--------
	Urgent care	$50 copay per visit	$50 copay per visit	-------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	$500 copay per visit.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$40 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	$500 copay per admission $500 copay per stay for Detoxification	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit (includes first post-partum visit)	Not covered	-------none--------
	Delivery and all inpatient services	$300 copay per admission	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No copay (100% covered) for prescribed medically necessary skilled home health services.	Not covered	Pre-Authorization required for Plan to pay
	Rehabilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Skilled nursing care	No copay (100% covered)	Not covered	100 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	30% coinsurance	Not covered	$2,000 per year. Pre-Authorization required for Plan to pay
	Hospice service	No copay (100% covered).	Not covered	Pre-Authorization required for Plan to pay
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-------none--------
	Glasses	Not covered	Not covered	-------none--------
	Dental check-up	Not covered	Not covered	Fluoride treatments by PCP for children.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, the, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Denver Health Medical Plan grievance department at 303-602-2261 or by fax at 303-602-2078.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $7,070**
- **Patient pays $ 470**

Sample Care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$150
Total	$470

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $4,620**
- **Patient pays $780**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	$780

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

DENVER HEALTH Medical Plan, Inc.

Career Service Authority / Denver Employee Retirement Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for:
Individual and Children | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the costs of covered services.
What is not included in the out–of–pocket limit?	The plan has no **out-of-pocket limit**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Form No.: COM_MKT_125-00
Creation/Rev Date 12/19/12

OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$40 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$20 copay per visit for chiropractor	Not covered	$20/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$200 copay per test	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	Discount Generic (30 day supply) Denver Health Pharmacy $4 copay Non Denver Health Pharmacy $8 copay Generic (30 day supply) Denver Health Pharmacy $10 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $15 copay Non Denver Health Pharmacy (30 day) $30 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	Not applicable	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay	waived if admitted
	Emergency medical transportation	$450 copay per trip	$450 copay per trip	-------none--------
	Urgent care	$50 copay per visit	$50 copay per visit	-------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	$500 copay per visit.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$40 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	$500 copay per admission $500 copay per stay for Detoxification	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit (includes first post-partum visit)	Not covered	-------none--------
	Delivery and all inpatient services	$300 copay per admission	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No copay (100% covered) for prescribed medically necessary skilled home health services.	Not covered	Pre-Authorization required for Plan to pay
	Rehabilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Skilled nursing care	No copay (100% covered)	Not covered	100 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	30% coinsurance	Not covered	$2,000 per year. Pre-Authorization required for Plan to pay
	Hospice service	No copay (100% covered).	Not covered	Pre-Authorization required for Plan to pay
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-------none--------
	Glasses	Not covered	Not covered	-------none--------
	Dental check-up	Not covered	Not covered	Fluoride treatments by PCP for children.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

Your Rights to Continue Coverage:

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For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

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Having a baby
(normal delivery)

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Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$150
Total	$470

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $4,620**
- **Patient pays $780**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	$780

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

DENVER HEALTH Medical Plan, Inc.

Career Service Authority / Denver Employee Retirement Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for:
Individual and Spouse | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the costs of covered services.
What is not included in the out–of–pocket limit?	The plan has no **out-of-pocket limit**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Form No.: COM_MKT_126-00
Creation/Rev Date 12/26/12

OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$40 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$20 copay per visit for chiropractor	Not covered	$20/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$200 copay per test	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	Discount Generic (30 day supply) Denver Health Pharmacy $4 copay Non Denver Health Pharmacy $8 copay Generic (30 day supply) Denver Health Pharmacy $10 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $15 copay Non Denver Health Pharmacy (30 day) $30 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	Not applicable	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay	waived if admitted
	Emergency medical transportation	$450 copay per trip	$450 copay per trip	-------none--------
	Urgent care	$50 copay per visit	$50 copay per visit	-------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	$500 copay per visit.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$40 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	$500 copay per admission $500 copay per stay for Detoxification	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit (includes first post-partum visit)	Not covered	-------none--------
	Delivery and all inpatient services	$300 copay per admission	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No copay (100% covered) for prescribed medically necessary skilled home health services.	Not covered	Pre-Authorization required for Plan to pay
	Rehabilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Skilled nursing care	No copay (100% covered)	Not covered	100 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	30% coinsurance	Not covered	$2,000 per year. Pre-Authorization required for Plan to pay
	Hospice service	No copay (100% covered).	Not covered	Pre-Authorization required for Plan to pay
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-------none--------
	Glasses	Not covered	Not covered	-------none--------
	Dental check-up	Not covered	Not covered	Fluoride treatments by PCP for children.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, the, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Denver Health Medical Plan grievance department at 303-602-2261 or by fax at 303-602-2078.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $7,070**
- **Patient pays $ 470**

Sample Care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$150
Total	$470

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $4,620**
- **Patient pays $780**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	$780

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the costs of covered services.
What is not included in the out–of–pocket limit?	The plan has no **out-of-pocket limit**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Form No.: COM_MKT_124-00
Creation/Rev Date 12/27/12

OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$40 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$20 copay per visit for chiropractor	Not covered	$20/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$200 copay per test	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	Discount Generic (30 day supply) Denver Health Pharmacy $4 copay Non Denver Health Pharmacy $8 copay Generic (30 day supply) Denver Health Pharmacy $10 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $15 copay Non Denver Health Pharmacy (30 day) $30 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $30 copay Non Denver Health Pharmacy (30 day) $60	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	Not applicable	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$150 copay per visit	$150 copay	waived if admitted
	Emergency medical transportation	$450 copay per trip	$450 copay per trip	-------none--------
	Urgent care	$50 copay per visit	$50 copay per visit	-------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per visit	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	$500 copay per visit.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$40 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	$500 copay per admission $500 copay per stay for Detoxification	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit (includes first post-partum visit)	Not covered	-------none--------
	Delivery and all inpatient services	$300 copay per admission	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No copay (100% covered) for prescribed medically necessary skilled home health services.	Not covered	Pre-Authorization required for Plan to pay
	Rehabilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$50 copay per visit.	Not covered	20 visits/year per type of therapy.
	Skilled nursing care	No copay (100% covered)	Not covered	100 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	30% coinsurance	Not covered	$2,000 per year. Pre-Authorization required for Plan to pay
	Hospice service	No copay (100% covered).	Not covered	Pre-Authorization required for Plan to pay
If your child needs dental or eye care	Eye exam	Not covered	Not covered	-------none--------
	Glasses	Not covered	Not covered	-------none--------
	Dental check-up	Not covered	Not covered	Fluoride treatments by PCP for children.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, the, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $7,070**
- **Patient pays $ 470**

Sample Care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$150
Total	$470

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $4,620**
- **Patient pays $780**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$0
Copays	$450
Coinsurance	$250
Limits or exclusions	$80
Total	$780

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

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Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Member Handbook 2014

DENVER HEALTH
Medical Plan, Inc.

Career Services Authority (CSA)
and Denver Employee Retirement Plan (DERP)
Non-Medicare Primary Denver Medical Care

HMO

1. Schedule of Benefits (Who Pays What)

	In Network	Out of Network
Annual Deductible		
Individual Family	No deductible applies.	Not applicable.
Annual Out of Pocket Maximum		
Individual Family	$6,350 $12,700 All copays apply to the out of pocket maximum.	Not applicable.
Lifetime maximum		
	■ No lifetime maximum	Not applicable.
Covered Providers		
	■ Denver Health and Hospital Authority providers and Denver Health Medical Center. Columbine network for chiropractic. See provider directory for a complete list of current providers.	Not applicable.
Medical Office Visits		
Primary care providers (Family Medicine, Internal Medicine and Pediatrics)	■ $25 copay per visit	Not covered.
Specialist	■ $40 copay per visit	Not covered.
Preventive Services		
Children Adults	■ No copayment (100% covered) Including but not limited to annual well visit, well woman exams, prenatal and post partum visits; colonoscopy, mammogram. For entire list see USPSTF list on our website at www.denverhealthmedicalplan.org	Not covered.
Maternity		
Prenatal Care Delivery, Inpatient and Well Baby Care	■ $0 copay per visit ■ $300 copay	Not covered.
Prescription Drugs		
	Denver Health Pharmacy (30-day supply) ■ Discount: $4 copay ■ Generic: $10 copay ■ Preferred Brand: $15 copay ■ Non-preferred Brand: $30 copay Denver Health Pharmacy or Denver Health Pharmacy by Mail (90-day supply) ■ Discount: $8 copay ■ Generic: $20 copay ■ Preferred Brand: $30 copay ■ Non-preferred Brand: $60 copay Non-Denver Health Pharmacy (30-day supply) ■ Discount: $8 copay ■ Generic: $20 copay ■ Preferred Brand: $30 copay ■ Non-preferred Brand: $60 copay (PA) Non-Denver Health Pharmacy (90-day supply) ■ Discount: $16 copay ■ Generic: $40 copay ■ Preferred Brand: $60 copay ■ Non-preferred Brand: $120 (PA) For drugs on our approved list, call Member Services at (303) 602-2100.	Not covered.

1. Schedule of Benefits (Who Pays What)

Inpatient Hospital		
	■ $500 copay per hospital stay ■ Preauthorization required Maximum on surgical treatment of morbid obesity of once per lifetime.	Not covered.
Outpatient/Ambulatory Surgery		
	■ $200 copay per surgery. ■ Preauthorization required	Not covered.
Diagnostics Laboratory and Radiology		
Laboratory, X-ray and CT MRI and PET scans	■ No copay (100% covered) ■ $200 copay per test	Not covered.
Other Diagnostic and Therapeutic Services		
Sleep study Radiation therapy Infusion therapy (includes chemotherapy) Injections Renal Dialysis	■ $400 copay per visit for facility or in-home study ■ $10 copay per visit ■ $10 copay per visit ■ $20 copay per visit (immunizations, allergy shots and any other injection given by a nurse is a $0 copay) ■ Covered at 100%	Not covered.
Emergency Care		
	■ $150 copay per visit	■ $150 copay (
Urgent Care		
	■ $50 copay per visit	■ $50 copay
Ambulance		
	■ $450 copay per incidence	■ $450 copay (
Behavioral Health, Mental Health Care and Substance Abuse		
Outpatient:	■ $40 copay per visit	Not covered.
Inpatient:	■ $500 copay per hospital stay. ■ Members can self refer to a Cofinity provider for mental health and substance abuse. ■ Preauthorization required	Not covered.
Therapies		
Rehabilitative: Physical, Occupational, and Speech Therapy	■ $50 copay per visit ■ 20 of each therapy per calendar year	Not covered.
Habilitative: Physical, Occupational, and Speech Therapy	■ $50 copay per visit ■ 20 of each therapy per calendar year ■ Preauthorization Required	Not covered.
Pulmonary Rehabilitation	■ 100% covered	Not covered.
Cardiac Rehabilitation	■ 100% covered	Not covered.
Durable Medical Equipment		
	■ 30% coinsurance applies; maximum benefit is $2,000 per calendar year ■ Preauthorization required	Not covered.

1. Schedule of Benefits (Who Pays What)

Hearing Aids		
Adults	■ Medically-necessary hearing aids prescribed by a DHMP Medical Care Network provider are covered every five years in network. For adults age over 18, 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. ■ Cochlear implants are now covered. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply.	Not covered.
Children	■ 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 no longer apply to the annual DME limit. ■ Cochlear implants are now covered. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply. ■ Preauthorization required	Not covered.
Prosthetics		
	■ 30% coinsurance applies; no maximum benefit, does not apply to DME maximum. ■ Preauthorization required	Not covered.
Orthotics		
	Medically necessary orthotics are reimbursed up to $100 per calendar year	Not covered.
Oxygen/Oxygen Equipment		
Oxygen	■ 100% Covered. ■ Preauthorization required	Not covered.
Equipment	■ 30% coinsurance applies; no maximum benefit, does not apply to DME maximum. ■ Preauthorization required	Not covered.
Organ Transplants		
	■ $1000 copay per admission. Only covered at authorized facilities. Coverage no less extensive than for other physical illness. 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. ■ Preauthorization required.	Not covered.
Home Health Care		
	■ No copay (100% covered) for prescribed medically necessary skilled home health services. ■ Preauthorization required.	Not covered.
Hospice Care		
	■ No copay (100% covered). ■ Preauthorization required.	Not covered.
Skilled Nursing Facility		
	■ No copay (100% covered). Maximum benefit is 100 days per calendar year at authorized facility. ■ Preauthorization required.	Not covered.
Dental Care		
	Not covered except for fluoride varnish at PCP visit.	Not covered.
Vision Care		
	■ Routine eye exam is not a covered benefit. Ophthalmology visits are covered under Specialist visits.	Not covered.

1. Schedule of Benefits (Who Pays What)

Chiropractic		
	■ $20 copay per visit. Maximum 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	
	Note: Massage therapy is not a plan benefit but DHMP offers a discount program through Columbine Chiropractic. Many chiropractic offices offer massage therapy as well. DHMP will not pay for massage therapy received at a Columbine Chiropractic office. Member must pay through discount program.	
Additional Benefits		
	■ 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! ■ 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 ■ eLearning module for parents-to-be. Online childbirth classes, free of charge to members. ■ Take Control of Your Health incentive plan	

Prior Authorization is required for, but not limited to, the following services: Durable medical equipment, genetic testing, home health care (including home infusion therapy); all hospital stays (including mental health or substance abuse-related stays), outpatient surgery (except those procedures performed in a physician's office), reconstructive surgery, non-formulary medications, skilled nursing facility care, transplant evaluations and hospice care, cochlear implants, clinical trials or study. Contact your primary care provider to request these services and provide the medical necessity information.

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

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

2. Title Page (Cover Page)

January 2014

The information contained in this Member Handbook explains the administration of the benefits of Denver Health Medical Plan (DHMP). DHMP is a health insurance plan offered by Denver Health Medical Plan, Inc., a state-licensed health maintenance organization (HMO). This Member Handbook is also considered your Evidence of Coverage document. Information regarding the administration of DHMP benefits can also be obtained through marketing materials, by contacting the Member Services Department at 303-602-2100 or toll-free at 1-800-700-8140 and on our web site at www.denverhealthmedicalplan.org. In the event of a conflict between the terms and conditions of this Member Handbook and any supplements to it and any other materials provided by DHMP, the terms and conditions of this Member Handbook and its supplements will control.

Coverage as described in this Member Handbook commences January 1, 2014 and ends December 31, 2014.

3. Contact Us

Member Services 303-602-2100 • Fax 303-602-2138

- Benefit questions
- Eligibility questions
- Billing questions
- Transportation (help schedule rides to and from appointments)
- Grievances (complaints)

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

- Pharmacy prior authorizations (medications that are not covered)
- Pharmacy claim rejections
- Medication cost
- Medication safety

Care Support Services 303-602-2080

- Learn how to navigate the health care system
- Get the most out of your health care plan
- Answer questions about DHMP's programs and services

Utilization Management 303-602-2140 • Fax 303-602-2128

- Authorization questions

Denver Health Appointment Center • 303-436-4949

24 Hour NurseLine • 303-739-1261

4. Table of Contents

5. Eligibility

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 primary 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, civil union or same sex domestic partner);
- A child married or unmarried until their 26th birthday as long as they are not eligible for health care benefits through their employer
- An unmarried child of any age who is medically certified as disabled and dependent upon you.

A child, meeting the age limitations above, may be a dependent whether the child is your biological child, your stepchild, your 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 may be eligible for care through our national network. For more information, call 303-602-2100.

For a common-law spouse, civil union or same sex domestic partner, you must complete the appropriate paperwork (affidavit). Contact your employer.

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, gender, 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.

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 toll free at 1-800-700-8140 (TTY/TTD users should call 303-602-2129 or toll free at 1-866-538-5288).

5. Eligibility

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.

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.

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;
- 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.

5. Eligibility

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 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.

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 Your Services and Obtain Approval of Benefits

Welcome to Denver Health Medical Plan

At DHMP our main concern is that you receive quality health care services.

As a member of DHMP you must receive your health care services within the contracted network.

Please see the Summary of Benefits for a breakdown of cost sharing.

Your Primary Care Provider

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

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

Selecting a Primary Care Provider

To find primary care providers that participate in the DHMP network, visit www.denverhealthmedicalplan.org and select "Find A Doctor/Provider." You may also contact Member Services at 303-602-2100 or toll-free at 1-855-700-8140 (TTY/TDD users should call 303-602-2129 or toll-free at 1-866-538-5288)

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

Changing Your Primary Care Provider

If you decide to select a new primary care provider, there is no need to tell us. You can change your selection at any time. Our web site provides the most up-to-date information on providers that participate in the DHMP network. Or call Member Services at 303-602-2100 if you need more information.

Specialty Care

If you think you need to see a specialist or other provider, you should contact your primary care provider. He/she will work with you to determine if you need to see a specialist, provide you with a referral, and help to coordinate your care.

Members may self refer for the following services: OB/GYN, Behavioral Health, and routine eye care.

Your Health Network

The DHMP Basic network is made up of all Denver Health clinics and facilities. This includes 8 community health centers, 15 school-based health centers and the main Denver Health Medical Center campus. The main campus includes the Webb Primary Care Center for outpatient care as well as the inpatient hospital facility.

To find a full list of DHMP network providers, visit www.denverhealthmedicalplan.org and click on Find a Doctor/Provider for our web based provider directory, or call Member Services at 303-602-2100.

If you need a service that is not offered by Denver Health Medical Center or you cannot get an appointment in a timely manner, you can be referred to a provider outside this network. However, you must have prior authorization for DHMP to pay for the services. If you have questions regarding this, call Member Services at 303-602-2100.

After Hours Care

Medical care after hours is covered. If you have an urgent medical need, you may visit any urgent care center that is convenient for you. You may also call the NurseLine 24 hours/day, 7 days/week at 303-739-1261. If you have a life or limb-threatening emergency, go to the closest emergency room or dial 9-1-1. No authorization is necessary.

Emergency Care

Emergencies are life-threatening conditions or symptoms that arise suddenly and unexpectedly. These symptoms are so severe that you need medical attention now to prevent loss of life or limb. If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. There is no need for prior authorization.

Care Outside the Health Plan Network

Care outside of the DHMP network may be covered if:

1. The type of care is not provided within the DHMP network, and
2. You receive a referral from your primary care provider or specialist, and
3. The referral is approved (authorized), in advance, by Utilization Management.

If you choose to see a provider who is not a participating provider without a referral from your primary care provider and/or 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.

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

Authorization Process

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

The following are examples of services that require approval before receiving the service (prior authorization):

- Hospital admissions (including mental health, inpatient rehabilitation, and substance abuse admissions).
- Outpatient surgery (except those procedures performed in a physician's office)
- Genetic testing
- Cochlear implants for children under age 18
- Coverage for services in a clinical trial or study
- Home health care (including home infusion therapy)
- Durable medical equipment
- Skilled nursing facility admissions
- Hospice care
- Transplant evaluations/procedures
- Referral to out-of-network specialists or facilities
- Urgent/emergent care admissions do not require prior authorization but will be reviewed concurrently.

Utilization Management staff is available to answer UM questions Monday through Friday, from 8:00 AM to 5:00 PM, except on holidays. If you have questions or concerns about the authorization process, specific cases, or UM decisions, please call us at 303-602-2140 or toll-free, 1-855-700-8140. A TTY/TDD line is available for the hearing- or speech-impaired at 303-602-2129. We also have bilingual staff and language assistance services available at no charge.

Nurse Line

DHMP members can call the Denver Health NurseLine 24 hours a day/7 days a week at 303-739-1261. This service is staffed by nurses trained to answer your questions. In some cases the Nurse Line representative can call in a prescription and save you a trip to urgent care.

Language Line Services

DHMP is committed to meeting our plan members' needs. DHMP contracts with Language Line Services, Inc. to provide translation services at no cost to our plan members. If you need an interpreter during your clinic visit, please tell the Appointment Center representative when you make your appointment. For further assistance, please contact Member Services at 303-602-2100 or toll-free at 1-855-700-8140. Our TTY/TDD number is 303-602-2129.

Access Plan

Denver Health Medical Plan has an Access Plan that evaluates all physicians, hospitals and other providers in the network to assure members have adequate access to services. This plan also explains DHMP's referral, coordination of care, and emergency coverage procedures. You may make an appointment to review the Access Plan on site at DHMP's offices, by calling Member Services at 303-602-2100 or toll-free at 1-855-700-8140.

When You Are Out of Town

When you are traveling, you may go to any hospital or urgent care center that is convenient for you. If you need emergency care, go to the nearest hospital or call 9-1-1. Following an emergency or urgent care visit out of network, one follow up visit is covered if you cannot reasonably travel back to your service area. Travel expenses back to the DHMP network are not a covered benefit. If you plan to be outside the DHMP service area and need your prescription filled, we have many network pharmacies across the country that you may use. Please check with Member Services at 303-602-2100 or toll-free at 1-855-700-8140 (TTY/TDD users should call 303-602-2100 or toll-free at 1-866-538-5288).

If you are a dependent residing, attending school or traveling outside of the Denver Health Medical Plan service area, you can call Member Services at 303-602-2100 for assistance in finding a network provider. Prescriptions are covered when filled at a network pharmacy, DHMP has a national prescription network. When urgent care or emergency services are needed, visit the closest facility or call 9-1-1.

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

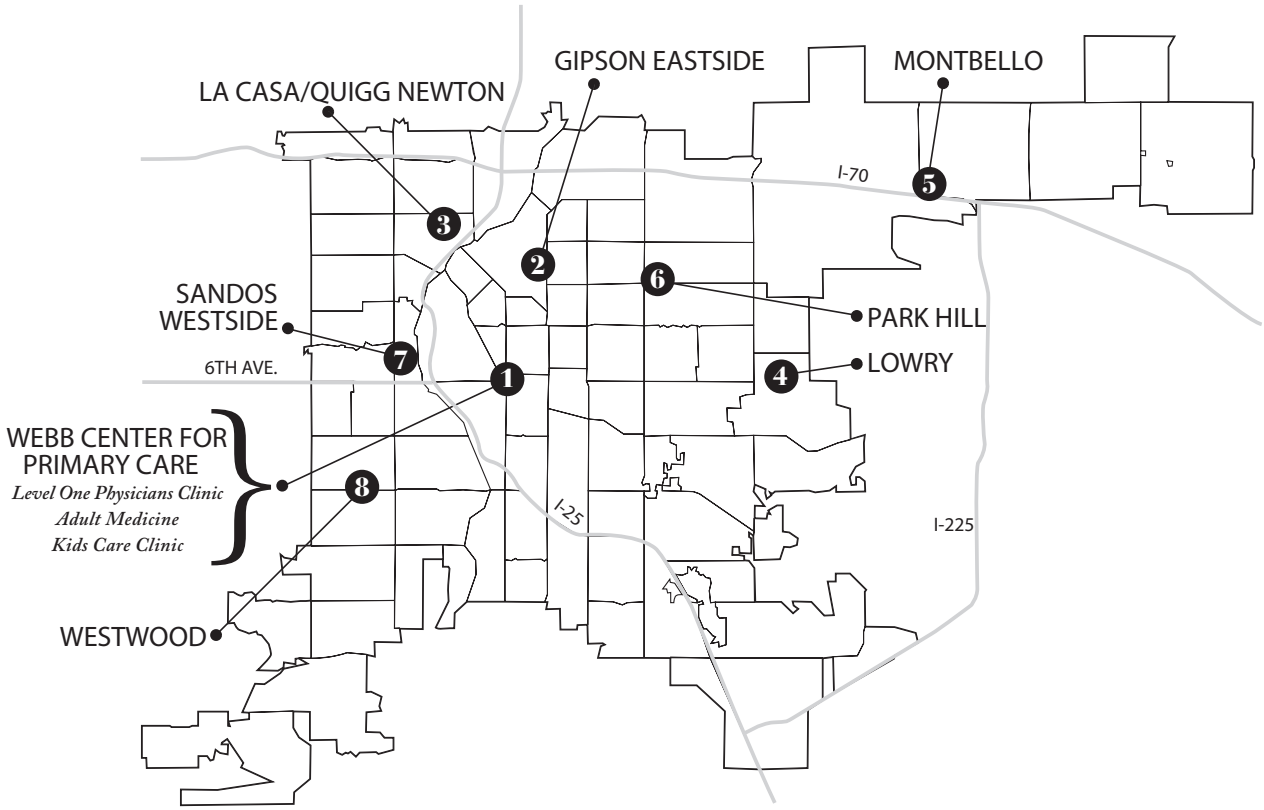
Change of Address

If you change your name, mailing address, or telephone number, contact your benefits manager.

Advance Directives

Advance directives are written instructions concerning your wishes about your medical treatment. These are important health care decisions and they deserve careful thought. Advance Directive decisions include the right to consent to (accept) or refuse any medical care or treatment, and the right to give advance directives. It may be a good idea to discuss them with your doctor, family, friends, or staff members at your health care facility, and even a lawyer. You can obtain more information about advance directives, such as living wills, medical durable powers of attorney, and CPR directives (do not resuscitate orders) from your primary care provider, 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.org.

Map of Denver Health Family Health Centers



FAMILY HEALTH CENTERS

1 ℞ **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
PHARMACY	303.602.8500

2 ℞ **GIPSON EASTSIDE**

501 28th St.	303.436.4600
Pharmacy	303.436.4600

3 ℞ **LA CASA/QUIGG NEWTON**

4545 Navajo	303.602.6700
Pharmacy	303.602.6700

4 **LOWRY**

1001 Yosemite St.	303.602.4545
Suite 100	

5 ℞ **MONTBELLO**

12600 E. Albrook Dr.	303.602.4000
Pharmacy	303.602.4025

6 **PARK HILL**

4995 E. 33rd Ave.	303.602.3720

7 ℞ **SANDOS WESTSIDE**

1100 Federal Blvd	303.436.4200
Pharmacy	303.436.4200

8 **WESTWOOD**

4320 W Alaska Ave	303.602.4660

1 HOSPITAL

DENVER HEALTH MEDICAL CENTER

777 Bannock St.	303.436.6000

ADULT URGENT CARE WALK-IN CLINIC

777 Bannock St.	303.602.2822

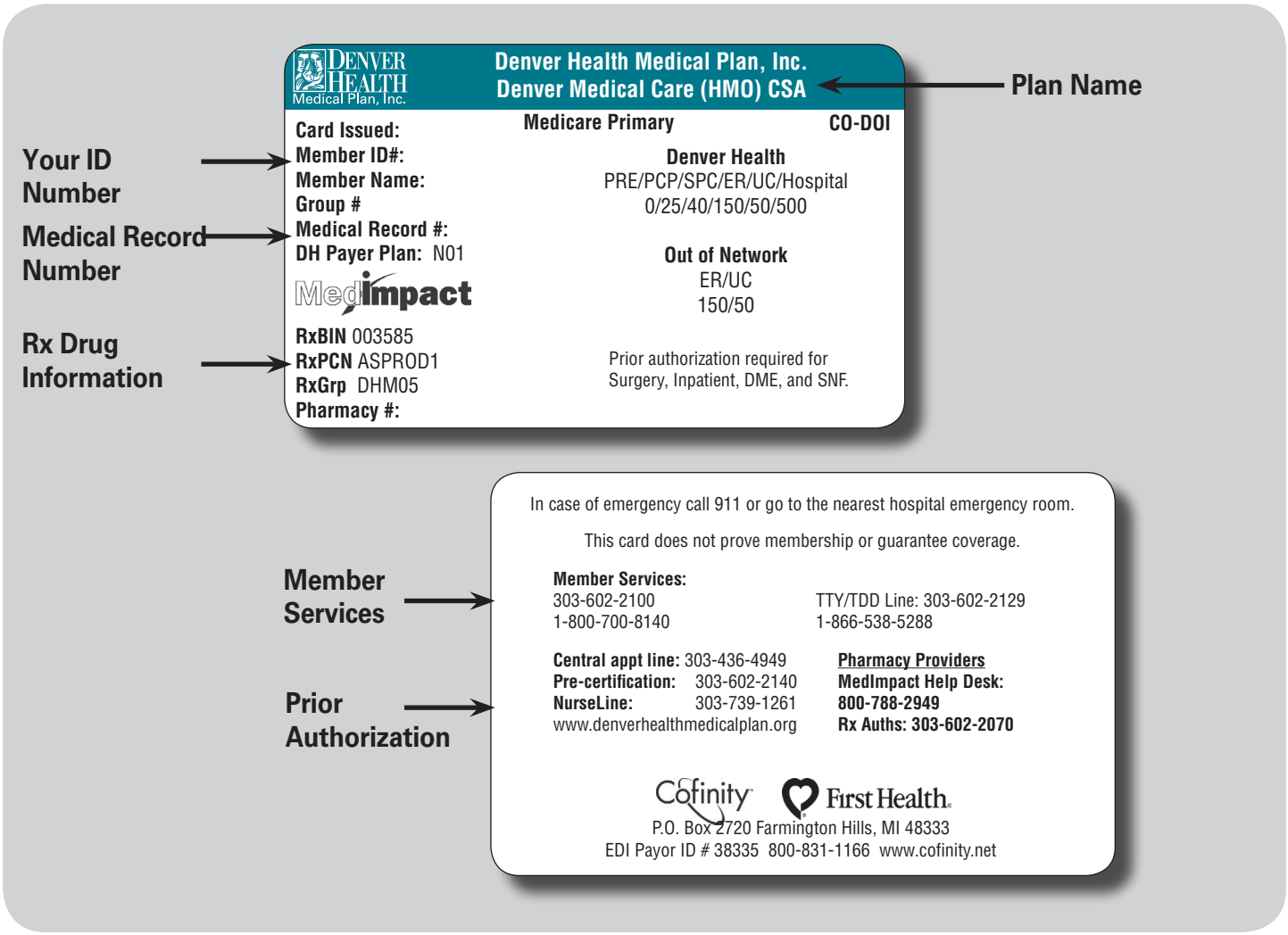
PEDIATRIC URGENT CARE CLINIC

777 Bannock St.	303.602.3300

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

Your Denver Health Medical Plan Identification Card

Keep your DHMP identification card with you at all times. Before receiving medical or prescription services, you must show your DHMP identification card. If you fail to do so, or misrepresent your membership status, claims payment may be denied. If you lose your identification card and need a new one, call Member Services at 303-602-2100 or toll-free at 1-855-700-8140 Monday — Friday 8 a.m. — 5 p.m. (TTY/TDD users should call 303-602-2129 or toll-free at 1-866-538-5288)



7. Benefits/Coverage (What is Covered)

Member Newsletter

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

Complex Case Management (CCM)

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

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

Complex Case Managers are available to:

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

Our goal is to assist you to:

- Regain and/or improve health or function
- Better understand your health conditions and concerns
- Understand your health care benefits and get the care you need
- Take a more active role in your care and treatment plan

Members or their caregivers may self-refer to gain access to these voluntary services. Complex Case Management services are provided at no cost to you and will not affect your plan benefits.

To participate in a Complex Case Management Program or to learn more about Complex Case Management, please call Care Support Services at 303-602-2080. You can also obtain more information about program eligibility and services at www.denverhealthmedicalplan.org.

Behavioral Health and Wellness Services

As a DHMP member, you have access to many services offered through our Behavioral Health and Wellness Services Department. Our Health Coaches can help you take a more active role in your health care by helping you enroll in an exercise program, eat better/lose weight, stop smoking, lower stress, take your medications, and manage chronic diseases like diabetes. We also offer monthly health and wellness talks as well as weekly education classes on health-related topics. Sometimes people feel stressed, worried, or depressed. The good news is that there are many things we can do to feel better. As a member, you can work with a counselor over the phone to learn new ways to deal with depression, anxiety and related problems. All of these services are no cost to you! To learn more or to sign up for any of these programs, please call Care Support Services at 303-602-2080 or toll-free at 1-855-700-8140 For TTY/TDD call 303-602-2129.

Your Benefits

It is important that you understand the benefits and cost sharing that apply to you. When in doubt, call the DHMP Member Services department at 303-602-2100 or toll-free at 1-855-700-8140. This is the best source for information about your health care plan benefits.

Office Visits

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

Primary Care Visit:
In network: $25 per visit
Out-of-network: Not covered

Specialty Visit:
In network: $40 per visit
Out-of-network: Not covered

Allergy Testing and Treatment

Allergy specialist visits are covered with a referral from your provider.

In network: $40 copay
Out-of-network: Not covered

Allergy testing is covered

In network: $0 copay
Out-of-network: Not covered

Allergy injections given by a nurse when no other services are provided are not subject to cost sharing.

Medically necessary allergy testing is covered.

7. Benefits/Coverage (What is Covered)

Autism Services

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

- Evaluation and assessment services;
- Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. See Therapies for Habilitative and Rehabilitative benefit limits for cost sharing.

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

Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism service providers:

In network:
Birth through age 8: 550 visits/year
Age 9 to age 19: 185 visits/year
All visits are 25 minute session increments
Out-of-network: Not covered

Clinical Trials and Studies

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

- The member's in network primary care provider recommends participation, determining that participation has potential therapeutic benefit to the member;
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
- Member has signed a statement of consent for participation in the clinical trial or study and understands all applicable copays, deductible and coinsurance will apply; and

Health care services excluded from coverage under the member's health plan will not be covered. DHMP will not cover any service, drug or device that is paid for by another entity involved in the clinical trial/study.

- The member suffers from a condition that is disabling, progressive, or life-threatening.
- Extraneous expenses related to participation in the clinical trial or study or an item or service that is provided solely to satisfy a need for data collection or analysis are not covered.

See **Definitions** section for more information.
Applicable cost sharing for type of service will apply.

Dietary and Nutritional Counseling

Coverage for health coach counseling is limited to the following covered situations:

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

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

Durable Medical Equipment, Prostethics and Orthotics

General

Durable medical equipment (DME) is covered if medically necessary and prior authorized by DHMP. This includes diabetic footwear. 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 primary care provider and request that the authorization be extended. All DME must be obtained from a DHMP network provider.

Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. The Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge. You will be billed for any additional items of DME, prosthetics, orthotics and/or necessary repairs and adjustments after the maximum benefit per year is paid by the Plan.

Deductible does not apply to Durable Medical Equipment.

In network:
- No cost for items less than $100
- 30% copay of total cost

Out-of-network: Not covered

Benefit Maximum: $2,000 per member per calendar year

Dressings/Splints/Casting/Strapping

Dressings, splints, casts and strappings that are given to you by a provider are covered and no copayment is required. The cost of purchased dressings splints, casts and strappings apply to the DME benefit maximum.

In network: 30% coinsurance
Out-of-network: Not covered

Benefit Maximum: $2,000 per member per calendar year

7. Benefits/Coverage (What is Covered)

Prosthetic Devices

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

Coverage

Coverage includes the following prosthetic devices:

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

In network: 30% coinsurance
Out-of-network: Not covered
Does not accrue toward annual DME Maximum

No benefit maximum.

Prosthetic Devices Exclusions:

- Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate in newborn members, as described above.
- Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
- More than one prosthetic device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Replacement of lost prosthetic devices.
- Repairs, adjustments or replacements necessitated by misuse.

Orthotic Devices

Coverage

- Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.
- Not subject to deductible.

Orthotic Devices Exclusions:

- Corrective shoes and orthotic devices for podiatric use and arch supports.
- Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate for newborn members is covered when prescribed by a network provider.
- Experimental and research braces.
- More than one orthotic device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Replacement of lost orthotic devices.
- Repairs, adjustments or replacements necessitated by misuse.

In network: Medically necessary orthotics are reimbursed up to $100 per calendar year
Out-of-network: Not covered

Diabetic Education and Supplies

If you have been diagnosed with diabetes by an appropriately licensed health care professional, you are eligible for outpatient self-management training and education, as well as coverage of your diabetic equipment and supplies, including formulary glucometers, test strips, insulin and syringes. These supplies are provided by your pharmacist with a prescription from your provider. Insulin pumps are covered through the DME benefit.

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

No copayments apply to early intervention services.

Benefit Maximum: 45 therapeutic visits 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."

7. Benefits/Coverage (What is Covered)

Emergency Services

Emergencies are life-threatening conditions or symptoms that arise suddenly and unexpectedly. These symptoms are so severe that you need medical attention now to prevent loss of life or limb. If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. No authorization is required.

Services for the treatment of an emergency are covered. See definition of "Emergency" in the Definitions section. 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 primary care provider.

Follow-up care following an emergency department visit must be received from a DHMP network provider, unless you are traveling outside the network area cannot reasonably travel to the service area. In this case, one follow up visit outside the network is covered. If you are admitted to a non-network hospital as the result of an emergency and then subsequently transferred in network, you will only be responsible for the copayment for the first inpatient admission.

Ambulance Service

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

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

In network: $50 copay
Out-of-network: $50 copay

Eye Examinations and Ophthalmology

Routine visual screening examinations are not covered. Other ophthalmology services are covered as a specialist visit as referred by your primary care provider.

Family Planning Services

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

The following are covered if obtained from a network provider and applicable cost sharing applies:

- 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: $0 copay
Out-of-network: Not covered

Tubal ligations, vasectomies, and abortions up to the 15th week of pregnancy are covered. You must receive a referral from an in network provider, if the service is not provided by your primary care provider.

There are some limitations; please see exclusions section.

Infertility Services

In network: Not covered
Out-of-network: Not covered

Hearing Tests and Hearing Aids

Children age 18 and under are covered at 100%, no maximum benefit applies. Hearing tests and fittings for hearing aids are covered under clinic visits and the applicable copayment applies. Hearing aids do not apply to DME benefit maximum.

Adults (age 19 and over):
In network: 30% coinsurance of with maximum benefit of $1,500. Member responsible for amount over $1,500.
Out-of-network: Not covered

Children (18 and under):
In network: 100% covered
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 with prior authorization. The device is covered at 100%. Appropriate cost sharing will apply to surgical services associated with the device.

Home Health Care

Home health care provided by an DHMP network home health care provider is covered. Coverage requires periodic assessment by your primary care provider. A referral by your primary care provider and prior authorization by DHMP are required.

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

Newborn and Postpartum

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

Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy, as well as audiology services, in the home are covered when prescribed by your primary care provider or specialist and prior authorized by DHMP. Periodic assessment and continued authorization are required to extend 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 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. This includes home infusion therapy. Home nursing services are provided only when prescribed by your primary care provider 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 network hospice program. Each hospice benefit period has a duration of three months. Hospice Services must be prior authorized by DHMP before you receive your care.

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

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

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

Hospice Facility

Hospice may be provided as 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 DHMP. This includes care by the hospice staff, medical supplies and equipment, prescribed drugs and biologicals and family counseling ordinarily furnished by the hospice.

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

Inpatient Hospital

Any admission to a hospital, other than an emergency admission, must be to an in network hospital and must be prior authorized by DHMP. Emergency hospitalization should be reported to DHMP at 303-602-2140 as soon as reasonably possible, preferably within 1 business day.

- Hospital services, including surgery, anesthesia, laboratory, pathology, radiology, radiation therapy, respiratory therapy, physical therapy, occupational therapy and speech therapy are covered. Oxygen, other gases, drugs, medications and biologicals (including blood and plasma) as prescribed are also covered. See "Limitations and Exclusions" section 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
Out-of-network: Not covered

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

Limitations: If you request a private room, the Plan 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.

7. Benefits/Coverage (What is Covered)

Immunizations

- There is no copay for covered 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 if they are provided at the Public Health Department at Denver Health. Prophylactic drugs for travel will be covered if prescribed by your primary care provider and if the drugs are on the Plan formulary. Some immunizations can be received in your primary care provider's office, so before visiting the Public Health Department at Denver Health, contact your primary care provider first for immunizations and prophylactic drugs.
- HPV vaccine is covered for eligible males and females 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 nurse, primary care provider, or specialist visit the required copayment will be requested.

Infusion Services

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

In network: $10 copay per visit
Out-of-network: Not covered

Injection Administration

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 primary care provider or specialist visit the required copayment will be requested.

In network: $20 copay
Out-of-network: Not covered

Laboratory and Pathology Services

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

Certain genetic tests, such as testing to determine risk for developing cancer, are covered with prior authorization.

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 primary care provider or any network obstetrician. You do not need a referral from your primary care provider to see a participating OB/GYN, physician, Certified Nurse Midwife or Nurse Practitioner. Prenatal visits are treated as preventive well-woman visits.

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: $0 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 DHMP network. Only emergency deliveries are covered outside of DHMP network facilities. Any sickness or disease that is a complication of pregnancy or childbirth will be covered in the same manner and with the same limitations as any other sickness or disease.

Mother and child may have a minimum hospital stay of 48 hours following a vaginal delivery or 96 hours following a Cesarean delivery, unless mother and attending physician mutually agree to a shorter stay. If 48 hours or 96 hours following delivery falls after 8:00 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.

Postpartum: Breastfeeding support and equipment is available at no cost to members with no cost sharing. Call 303-602-2100 for more information.

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 food to enter the small intestine or impairment of small bowel that impairs digestion and absorption of an oral diet is covered.

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 network facility.

Prior authorization is required for non-emergency admissions. Notification to the Plan should be made as soon as reasonably possible, preferably within one business day of an emergency admission.

In network: 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 DHMP network without a referral from your primary care provider.

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 DHMP network without a referral from your primary care provider.

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
Out-of-network: Not covered

Outpatient:
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

Note: Court ordered mental health services are covered. Applicable copays/coinsurance apply

Newborn Care

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

The Plan 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 DHMP network providers and must be prior authorized by the Utilization 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 designed 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 stay
Out-of-network: $150 copay per stay

Ostomy Supplies

Colostomy, ileostomy and urostomy supplies are covered.

In network: 30% coinsurance
Out-of-network: Not covered

Oxygen/Oxygen Equipment

Equipment for the administration of oxygen is covered. Oxygen is covered, and no cost sharing is required. There is no benefit maximum.

In network: 100% covered; equipment: 30% coinsurance
Out-of-network: Not covered

7. Benefits/Coverage (What is Covered)

Pharmacy Benefits

DHMP provides a pharmacy benefit that covers medically necessary drugs as required by the requirements and guidelines discussed below. Depending upon where you have your prescription filled, copays and restrictions may vary. Prescription copay information for your plan is listed in the Pharmacy Benefits chart.

Where You Can Fill Your Prescription

- DHMP offers thousands of pharmacies nationwide for you to fill your prescriptions. These pharmacies include any Denver Health Pharmacy, Albertsons, King Soopers, Rite-Aid, Safeway, Target, Walgreens, and more.
- DHMP has conveniently located Denver Health Pharmacies in many of the Denver Health clinics. While you have the choice to fill your prescription at any network pharmacy, filling your prescriptions at Denver Health Pharmacies will give you the lowest copay and allows your provider to see your prescription fill information. This helps your provider to give you the most complete care at each visit.

Remember, to fill a prescription at a Denver Health Pharmacy your prescription must be written by a Denver Health provider.

Denver Health Refill Request Line
1-888-436-3442

Denver Health Pharmacy by Mail
(requires credit card registration/order form)
Monday-Friday, 9am-5pm
303-602-2326

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

Gipson Eastside Pharmacy 303-436-4600, #7
501 28th Street

Infectious Disease (ID) Pharmacy 303-602-8762
605 Bannock Street

La Casa/Quigg Pharmacy 303-602-6700
4545 Navajo Street

Montbello Pharmacy 303-602-4025
12600 Albrook Drive

Sandos Westside Pharmacy 303-436-4200
1100 Federal Blvd

To find a pharmacy near you visit www.denverhealthmedicalplan.org or call Member Services.

Refilling Your Prescription

- It is best to call to refill your prescription 3-5 working days before you need your refill. Your prescription may be refilled once 75% has been used. This is calculated using the original prescription directions. If the directions have changed please contact your pharmacy or provider for an updated prescription. If your prescription directions have changed or you need an early refill, please let the pharmacy know ahead of time. The pharmacy will need extra time to talk to your provider to get a new prescription or get authorization to fill your prescription early.
- When you use Denver Health Pharmacies you may order your prescriptions by calling the Denver Health Refill Request Line (which is also the number on your prescription bottle), or by visiting www.denverhealthmedicalplan.org.

Mail Order Pharmacy - Denver Health Pharmacy by Mail

- You can save time and money by signing up to have your prescriptions delivered to your home by mail. Ask your provider to write your prescriptions for a 90 day supply so you can get your prescriptions by mail. A registration/order form is required to sign up and you must keep a credit card on file to pay for your medications.
  - » Registration/order forms are available at www.denverhealthmedicalplan.org, at any of the Denver Health pharmacies, or by calling the Denver Health Pharmacy by Mail at 303-602-2326 or toll-free at 1-866-347-3345.
- Medications are sent through the U.S. Postal Service within the state of Colorado. Medications that need refrigeration can be mailed. However controlled substances cannot be filled by Denver Health Pharmacy by Mail.

90-Day Supply at Retail

- Your pharmacy benefit allows you to get a 90 day supply of medication at any Choice 90 participating retail pharmacy. To find out if your drug and/or pharmacy are eligible for this benefit visit www.denverhealthmedicalplan.org and click the "Drug Formulary Search" link for your plan or call Member Services.

7. Benefits/Coverage (What is Covered)

Your Formulary

- The DHMP formulary is a list of covered drugs that shows the copayment tier and prior authorization requirements for each medication. We have selected the tiers and determined the criteria for prior authorization based on efficacy and cost-effectiveness. There is a different copayment for each tier. The formulary helps providers choose the most appropriate and cost-effective drug for you.
  - » Your formulary covers many drugs including oral anti-cancer drugs.
- Some drugs require a prior authorization from the Plan. These drugs are noted on the formulary as "PA". Clinical information on why the PA drug is needed is required on the prior authorization request. DHMP will review the prior authorization request according to our criteria for medical necessity and determine if the drug will be covered.
- If your provider writes a prescription for a drug that is not on the formulary, there may be a covered drug that works just as well for you. If your provider does not want to change the drug to a formulary alternative, you will need a prior authorization from the Plan.

Please visit www.denverhealthmedicalplan.org where you will find:

- A list of pharmaceuticals, including restrictions and preferences
- Information on how to use the pharmaceutical management procedures
- An explanation on limits or quote
- Information on how practitioners must provide information to support an exception request
- The process for generic substitution, therapeutic interchange and step-therapy protocols

You may also call and request a printed copy of this information by calling Member Services.

Generic and Brand Name Drugs

- You can save money by using generic drugs which have lower copays. Generic drugs are approved by the U.S. Food and Drug Administration for safety and effectiveness and are made using the same strict standards that apply to the brand name alternative. By law, generic drugs must contain identical amounts of the same active drug ingredient as the brand name drug.
- A generic preferred program is in place. This means if you fill a prescription with a brand name drug when a generic is available, you will have to pay the copay plus the difference in cost between the generic and the brand name drug. If your provider feels you need the brand name drug, they can fill out a prior authorization request form to tell DHMP why the brand is needed. If approved you will only need to pay the brand copay.

Drug Exclusions (See General exclusions and limitations for additional limitations)

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

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

	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**

7. Benefits/Coverage (What is Covered)

Preventive Care

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 web site at: www.denverhealthmedicalplan.org. Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the following chart for your cost-sharing that may apply to preventive care services received by a network provider. Please keep in mind the following:

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

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: • Prenatal visits • Medical history • Physical exam of pelvic organs including PAP test • Vaginal smear • Physical exam of the breasts • Rectal exam including FOBT • Consultation for birth control, if requested • Urinalysis	$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

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

Radiology/X-Ray Diagnostic and Therapeutic Services

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

In network: No copay 100% covered
Out-of-network: Not covered

Radiation Therapy:
In network: $10 copay per visit
Out-of-network: Not covered

MRI and PET Scans:
In network: $200 copay
Out-of-network: Not covered

Renal Dialysis

Renal dialysis is covered if provided at an authorized facility.

In network: No copay. 100% covered.
Out-of-network: Not covered

7. Benefits/Coverage (What is Covered)

Skilled Nursing Facility/Extended Care Services

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

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

Benefit Maximum: 100 days per calendar year

Sleep Studies

Covered if provided at a network facility or in home.

In network: $400 copay
Out-of-network: Not covered

Smoking Cessation

Talk to your primary care provider 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, if approved. You also have access to a Health Coach who can assist and support you through the process. For more information, contact Member Services at 303-602-2100.

Substance Abuse Services

Referral by your primary care provider and prior authorization by DHMP 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 one business day.

In network: $500 copay per admission
Out-of-network: Not covered

Inpatient Substance Abuse Rehabilitation Services

Your admission and treatment must be in a network facility and prior authorized by the Utilization Management Department.

In network: $500 copay per admission
Out-of-network: Not covered

Exclusions: Maintenance, residential care or aftercare following a rehabilitation program

Outpatient Substance Abuse 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 DHMP network.

In network: $40 copay
Out-of-network: Not covered

Note: Court ordered mental health services are covered. Applicable copays/coinsurance apply.

Surgery Services

Inpatient Surgery

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

In network: $500 copay per admission
Out-of-network: Not covered

Outpatient Surgery

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

In network: $200 copay
Out-of-network: Not covered

7. Benefits/Coverage (What is Covered)

Oral/Dental Surgery

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

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

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

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

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

Breast Surgery

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

Reconstructive Surgery

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

Transplants

Corneal, kidney, kidney-pancreas, heart, lung, heart-lung, and liver transplants 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 Utilization Management Department.

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

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

In network: $1000 copay
Out-of-network: Not covered

Benefit Maximum: Two transplant procedures, regardless of whether the same or a different organ, per member per lifetime.

7. Benefits/Coverage (What is Covered)

Therapies

Habilitative Services

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

In network: $50 copay per visit
Out-of-network: Not covered

Prior Authorization Required.

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy to learn skills for the first time or maintain current skills

Rehabilitative Services

- Physical therapy, occupational therapy and speech therapy will be authorized only until maximum medical improvement is reached or the annual benefit is exhausted, whichever comes first. However, early intervention services for children up to age 3 with developmental delays are covered without regard to maximum medical improvement. See "Early Intervention Services." .

  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.

- **Cardiac Rehabilitation:** Treatment in a cardiac rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

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

- **Pulmonary Rehabilitation:** Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

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

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

Non-network providers

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

- Provided under prior written referral by a participating primary care provider and prior authorized by the Utilization Management department or
- Provided in an Emergency or urgent circumstance, and notification is made to the Utilization Management department as soon as reasonably possible, preferably within 1 business day.

General Exclusions

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

- **Adaptive Equipment/Corrective Appliances:** Artificial aids; adaptation to telephone for the deaf; replacement of artificial eyes if lost, stolen or damaged; reading aids, vision enhancement devices; cochlear implants for ages 18 and over; wheelchair ramps; home remodeling or installation of bathroom equipment; prosthetic devices (except for artificial limbs and breast prostheses).
- **Ambulance Services:** Ambulance service for non-emergency care or transportation except as requested by DHMP.
- **Artificial Hair:** Wigs, artificial hairpieces, hair transplants or implants, even if there is a medical reason for hair loss.
- **Care Not Medically Necessary:** Medical care, procedures, equipment, supplies, and/or pharmaceuticals that are not consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) services and interventions, not in widespread use, are based on scientific evidence.
- **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 18 and under-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 (primary care provider) as medically necessary as a result of trauma.
- **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 DHMP. 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:** Some drugs are not covered at all. These include drugs for the following: cosmetic use (anti-wrinkle, hair removal, and hair growth products), dietary supplements, blood or blood plasma (anti-hemophilic factor VIII and IX are covered), infertility, over-the-counter drugs (unless listed in the formulary), pigmenting/de-pigmenting, therapeutic devices or appliances (unless listed in the formulary), prescription vitamins (unless listed in the formulary), investigational or experimental treatments.

8. Limitations and Exclusions (What is Not Covered and Pre-Existing Conditions)

- **Experimental Procedures and Drugs:** Medical care, procedures, equipment, supplies, and/or pharmaceuticals determined by DHMP to be experimental, investigational, or not generally accepted in the medical community are not covered. This means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing, treatment, or pharmaceutical drug efficacy and appropriateness.
- **Extended Care:** Sanitarium, custodial or respite care (except as provided under Hospice Services), maintenance care, chronic care and private duty nursing.
- **Eyewear:** Glasses, contacts, all eyewear except as noted in specific plan benefits.
- **Family Planning and Infertility:** Reversal of voluntarily induced infertility (sterilization); 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.).
- **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.
- **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.
- **Medical Food:** Food products for cystic fibrosis or lactose or soy intolerance or other food allergies.
- **Neurostimulators:** Replacements or repairs, including batteries.
- **Obesity:** Commercial weight loss programs or exercise programs, , are not covered benefits although discount programs may be available.
- **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) are not covered. This includes vitamins, minerals or special diets, even if prescribed by a physician (except medical food for children with inherited enzymatic disorders) with the exception of formulary prescription items such as electrolytes, certain vitamins and minerals listed in the Denver Health Medical Plan formulary.
- **Paternity Testing**
- **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.
- **Refractive Surgery:** Vision correction surgery such as Lasik. Except as noted in specific plan benefits.
- **Residential Treatment:** Residential treatment facilities that provide 24-hour care with counseling, therapy and trained staff. Long term, non-structured residential treatment.
- **Transplants:** Organ transplants not listed in Overview of Covered Services; donor-related expenses for DHMP members who are donating to an individual who is not a DHMP member.
- **Vocational Rehabilitation:** Vocational rehabilitation, services related to screening exam or immunizations given primarily for insurance, licensing, employment, weight reduction programs, or for any other non-preventive purpose.

8. Limitations and Exclusions (What is Not Covered and Pre-Existing Conditions)

- **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

About Your Medical Benefits

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

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 table at the beginning of this handbook. You are responsible for all expenses incurred for non-covered services.

Benefit Maximums

Benefit maximums are the limits set by DHMP on the number of visits per calendar year or services per lifetime.

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.

Out-of-Pocket Maximum

This is the maximum amount you pay every year. Deductibles, coinsurance and copays apply to the out-of-pocket maximum.

10. Claims Procedure (How to File a Claim)

How to File a Claim

For Medical Service

When you receive health care services, you must show your provider your identification card. Your identification card gives your provider important information about your benefits, 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, coinsurance or deductible, if applicable, and should pay them directly to your provider.

There are situations in which you may need to file a claim for care you receive. If you receive emergency or urgent care from a provider outside of the DHMP network, you may be asked to pay the entire bill or a portion of the bill at the time of service. You may be required to pay the entire amount to the provider at the time of service. DHMP will reimburse you up to the limits noted in 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
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992

To be reimbursed for pediatric hearing aids, or 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 eligible up to the benefit maximum. Claims submitted later than 120 days after the date of service may be denied due to late filing.

Authorized claims that were part of a utilization management review, will be paid within 30 days of receipt.

For Pharmacy Service

Present your DHMP identification card at any network pharmacy when you have your prescriptions filled. You are responsible for paying the pharmacy copayment. If you are out of the network area and cannot locate a network pharmacy, please call the Member Services Department at 303-602-2100 or toll-free at 1-855-700-8140 for information on how to get your prescription filled. If you pay the full cost for an eligible prescription medication, you have 180 days to mail your pharmacy receipt, along with your name, mailing address and member ID number, to the following address:

Pharmacy Department
DHMP
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.

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 toll-free at 1-855-700-8140, 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 toll-free at 1-855-700-8140. You may also write to:

DHMP
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 Appeals and Complaints (Grievances) section.

Claims Timeframes

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

10. Claims Procedure (How to File a Claim)

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.

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.

10. Claims Procedure (How to File a Claim)

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.

When Another Party Causes Your Injuries or Illness

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

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

Disclosure of Health and Billing Information to Third-Parties

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

Venue

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

11. General Policy Provisions

Privacy/HIPAA Information

Confidential Information

DHMP is committed to protecting your privacy. All patient information is kept confidential. In addition, we will not discuss any of your Protected Health Information (PHI) with anyone other than yourself without approval. If you'd like for us to discuss your information with another family member, you will need to fill out the Designation of Personal Representative (DPR) form (see Attachment B in your handbook). Your handbook can be accessed on our web site at www.denverhealthmedicalplan.org, or you may call Member Services at 303-602-2100 and request a hard copy be mailed to you.

Also, complete privacy information is available on our web site at www.denverhealthmedicalplan.org, or you may call Member Services and request it be mailed to you.

Original Effective Date: April 14, 2003
Revised Effective Date: September 23, 2013

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

PLEASE REVIEW IT CAREFULLY.

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

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

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

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

Our Uses and Disclosures:

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

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

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

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

State and Federal Laws Pertaining to Personal Health Information

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

- If you are injured or unconscious, we may share PHI with your family or friends to ensure you get the care you need and talk about how the care will be paid for.
- To a personal representative designated by you or by law.

- To state and federal agencies that regulate us, such as the US Department of Health and Human Services, Colorado Division of Insurance, Colorado Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing.
- For public health activities. This may include reporting disease outbreaks or helping with product recalls.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities, such as: audits, inspections, licensure, and disciplinary actions.
- To a court or administrative agency, for example, pursuant to a court order or search warrant.
- For law enforcement purposes or with a law enforcement official.
- To a government authority regarding child abuse, neglect, or domestic violence.
- To respond to organ and tissue donation requests and work with a funeral director or medical examiner.
- For special government functions, such as for national safety.
- For job-related injuries because of state worker compensation laws.

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

Other uses and Disclosures of Health Information:

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

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

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

Your Rights Regarding Personal Health Information

The following are **your rights** with respect to your health information. If you would like to exercise the following rights, please contact the Privacy Officer by telephone at (303) 602-2004, facsimile at (303) 602-2074, and via email at privacyofficerdhmp@dhha.org, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m., or by US mail at or walk-in at Denver Health Medical Plan, Inc. Attn: Privacy Officer at 938 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 our Privacy Officer, and must state the specific restriction requested and to whom that restriction would apply

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

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

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

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

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

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

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

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

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

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

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. We are **not** required to provide you with an accounting of the following:
  1. Any information collected prior to April 14, 2003;
  2. Information disclosed or used for treatment, payment, and health care operations purposes;
  3. Information disclosed to you or pursuant to your authorization;
  4. Information that is incident to a use or disclosure otherwise permitted;
  5. Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
  6. Information disclosed for national security or intelligence purposes;
  7. Information disclosed to correctional institutions, law enforcement officials, or health oversight agencies;
  8. 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 Privacy Officer. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Please be advised that oral, written, and electronic PHI is protected internally. In the case of a breach, we have a duty to notify affected individuals of a breach of PHI

- ***You have a right to receive a copy of this notice upon request at any time***. Requests for a copy of this notice should be directed to the Privacy Officer.

Questions or Complaints

If you have any questions about this notice, how we use or share information, or if you believe your privacy rights have been violated, please contact the Privacy Officer at (303) 602-2004, facsimile at (303) 602-2074, or via email at privacyofficerdhmp@dhha.org, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. You may also contact us by US mail at Denver Health Medical Plan, Inc. Attn: Privacy Officer at 938 Bannock Street, Mail Code 6000, Denver, CO 80204.

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

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

Member Rights and Responsibilities

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

Member's Rights:

- Have access to practitioners and staff who are committed to providing quality health care to all members without regard for religion, race, national origin, handicap, sex or sexual orientation, or age.
- Receive medical/behavioral health care that is based on objective scientific evidence and human relationships. A partnership based on trust, respect, and cooperation among the provider, the staff and the member will result in better health care.
- 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, disability, or participation in a publicly financed program.
- To choose or change your primary care provider within the network of providers, to contact your primary care provider whenever a health problem is of concern to you and arrange for a second opinion if desired.
- 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.
- Get copies of your medical records or limit access to these records, according to state and federal law;
- Ask for a second opinion, at no cost to you;
- To know the names and titles of the doctors, nurses, and other persons who provide care or services for the member.
- A candid discussion with your provider about appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.
- A right to participate with providers in making decisions about your health care.
- To request or refuse treatment to the extent of the law and to know what the outcomes may be.
- 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 DHMP network. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered service.
- To learn more about your primary care provider and his/her qualifications, such as medical school attended or residency, go to www.denverhealthmedicalplan.org and click on Find a Doctor/Provider for our web based provider directory or call Member Services at 303-602-2100.
- 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, abuse or change in eligibility status at the time of service.
- To receive a standing referral, from a primary care provider 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.
- To voice a complaint about or appeal a decision concerning the DHMP organization or the care provided and receive a reply according to the grievance/appeal process.

11. General Policy Provisions

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 DHMP network without getting a referral from your primary care provider.
- To see your current non-network provider for prenatal care, until after delivery of the baby if you become a member of DHMP during your second or third trimester. This is dependent upon the non-network provider agreeing to accept DHMP's arrangements.

To continue to see your non-network doctor(s) or provider(s), when medically necessary, for up to 60 days after becoming a DHMP member. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

- For DME, DHMP will authorize up to 75 days from a non-network DME provider. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

Member's Responsibilities:

- To treat providers and their staff with courtesy, dignity and respect.
- To pay all premiums and applicable cost sharing (i.e. deductible, coinsurance, copays).
- To make and keep appointments, to be on time, call if you will be late or must cancel an appointment, and to have your DHMP identification card available at the time of service and pay for any charges for non-covered benefits.
- To report your symptoms and problems to your primary care provider and to ask questions, and take part in your health care.
- To learn about any procedure or treatment and to think about it before it is done.
- To think about the outcomes of refusing treatment that your primary care provider suggests.
- To get a referral from your primary care provider 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 Member Services representative with any questions.
- Inform providers or a representative from DHMP when not pleased with care or service.

DHMP Records

You have the right to examine, without charge, DHMP's administrative office or other specified locations, and certain documents of the Plan, such as detailed annual reports and plan descriptions. You may obtain copies upon written request to the DHMP Director of 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 members in accordance with all applicable State and Federal laws, including HIPAA. In accordance with HIPAA, DHMP may use any and all of a member's medical, billing and related information for the purposes of utilization review, care management, quality review, processing of claims, processing of appeals, payment, collection and subrogation activities, financial audit and coordination of benefits, to the extent permitted by HIPAA. Members authorize DHMP's use of this type of information for health plan operations when they sign the enrollment form or approve it online. Outside of these activities, DHMP will not release any information that would directly or indirectly indicate a member is receiving or has received Covered Services, unless authorized to do so by the member or HIPAA. DHMP will advise its employees, agents, and subcontractors, if any, that they are subject to these confidentiality requirements.

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

To make a request, call Member Services at 303-602-2100 or toll-free at 1-855-700-8140. Members also have the right to inspect and obtain copies of their medical records maintained by DHMP network providers. Please contact the individual provider for more details.

11. General Policy Provisions

Notice of Privacy Practices

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

The DHMP Notice of Privacy Practices is available on the DHMP web site at www.denverhealthmedicalplan.org. A new notice will be provided if there is any material change in our practices. You may, at any time, obtain a copy of the notice by contacting Member Services at 303-602-2100 or by calling toll-free at 1-855-700-8140.

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 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 DHMP network unless otherwise directed by your primary care provider and authorized by DHMP.

Affirmative Statement about Incentives

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

DHMP affirms the following regarding utilization management (UM) practices:

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

Please feel free to contact DHMP at 303-602-2100 should you have questions regarding this practice.

Relationship between DHMP and network providers

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

Statement of Appropriate Care

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

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

If you feel that a DHMP representative or network provider has violated any of the above principles, you can contact the Member Services department at 303-602-2100 or toll-free at 1-855-700-8140.

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.

Quality Improvement Program

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

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

Please visit www.denverhealthmedicalplan.org or call Member Services to learn more about our Quality Improvement Program such as program goals, processes, outcomes and specific measurements.

12. Termination/Nonrenewal/Continuation

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.

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.

13. Appeals and Complaints

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 expression of dissatisfaction about the quality of care you receive, the failure of a provider or the Plan to accommodate your needs, an unpleasant experience or any other service issue, including health plan benefit payment decisions.

An Appeal is a written or oral request that the Plan review an adverse decision about a requested medical service, care or treatment, or benefit payment decisions. An adverse decision is defined as a denial of a preauthorization for a covered benefit; a denial of benefits based on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a rescission or cancellation of coverage that is not attributable to failure to pay premiums and that is applied retroactively; a denial of benefits on the grounds that the treatment or service is experimental or investigational; or a denial of coverage based on initial eligibility determination. There are two types of an Appeal: (1) a pre-service appeal and (2) a post-service appeal. A pre-service appeal is defined as a request to change an adverse determination for care or service that the organization must approve, in advance of the member obtaining care or services. A post-service appeal is defined as a request to change an adverse determination for care or services that has already been received by the member.

Who Can File an Appeal

An appeal can be requested by you (the member), a person that you designate, such as a relative, friend, advocate, ombudsman, an attorney, or any physician, to act on your behalf as your appointed representative. To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a Designation of Personal Representative Form. You may obtain a copy of the Designation of Personal Representative Form at the end of this Member Handbook or call the Member Services Department at (303) 602-2100 to learn how to name your appointed representative. Upon receipt of the completed Designation of Personal Representative Form, we will process the appeal.

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 (303) 602-2100 or toll-free at 1-855-700-8140, TTY/TDD users should call 303-602-2129. You may also file a grievance by completing the Member Complaint and Appeal Form that is located at the end of this Member Handbook or via our web site at www.denverhealthmedicalplan.org. You may mail or fax your Grievance to the following address:

DHMP
ATTN: Grievance and Appeal Department
777 Bannock St., MC 6000
Denver, CO 80204-4507
Fax: (303) 602-2078

The Grievance team will conduct an investigation of your grievance. You will receive a written letter providing a resolution to your grievance within 30 calendar days.

How to File an Appeal

If you have received a letter stating that the requested service, care or treatment was denied, the decision is called an adverse determination and is subject to the appeal process. Before an appeal is filed, your physician may hold a peer-to-peer conversation with the Medical Director who rendered the adverse determination.

Peer-to-Peer Conversation

Your physician has the opportunity to hold a peer-to-peer conversation with the Medical Director regarding an adverse determination. Your physician must call the Utilization Management department at 303-602-2140 to initiate the peer-to peer conversation. The conversation must occur within five calendar days of the request for a peer-to-peer conversation.

Timeframes for Appeals

There are two types of appeals: (1) a pre-service appeal, or (2) a post-service appeal. Additionally, there are two levels of internal appeals: (1) a first level appeal and (2) a voluntary second level of appeal. The 1st level Appeal request must be received within 180 calendar days after the date you received notice of the initial denial.

First Level Appeal Reviews

First level pre-service appeal reviews must be evaluated by a physician reviewer with the clinical expertise in the same or similar specialty to evaluate the requested service. The physician reviewer will not have been involved in any prior decision of the matter nor will be a subordinate of any previous decision makers or have a financial interest in the appeal or outcome of the review. For first level post-service appeal requests, a physician reviewer is not required to evaluate the request.

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 20 calendar days following receipt of your request for an appeal review. The notice letter will include 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 Member Handbook provision, guideline, criteria or other documents relied upon in making the decision.

The notice will also describe the way in which to obtain a copy of any applicable guideline or criteria used and give you information about your option for a voluntary second level review.

Voluntary Second Level Appeal Reviews

If you do not agree with the outcome of the first level appeal decision, you may request another review, in writing, called a "voluntary second-level appeal" within thirty (30) days of the first level adverse determination. You may file the voluntary second level appeal request by completing the Member Complaint and Appeal Form that is located at the end of this Member Handbook or by obtaining the Form via our web site at www.denverhealthmedicalplan.org.

An Appeals Committee will conduct a second level review. All committee members will not have been involved in any prior decision of your issue nor be subordinates of previous decision makers. You have the right to participate in the second level review in person or by telephone conference but are not required to. You will be notified, in writing, of the Appeals Committee's decision within ten (10) days.

You may request a copy of the materials we intend to present at the review. You must submit your request at least five days before the Committee review meeting. We 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.

All comments, documents, records and other information about the request will be considered. Our response 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

You have the option of an independent external review by qualified experts upon the denial of a request for coverage. In order to request an independent external review, you must have pursued at least one level of the internal appeal process or have pursued an expedited review of a denial of a benefit. You must file the request for an external review within four (4) months of receipt of the first level review decision or within sixty (60) calendar days of receipt of the second level review decision. You may also request an expedited external review. Upon timely receipt of your request for an independent external review, DHMP will send you a letter describing the certified independent review entity that the Division of Insurance has selected to conduct the review. Please contact the Grievance and Appeal Department at (303) 602-2261 to have the consent form sent to you.

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 45 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 the 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 three working days of notification, if the initial notification was by telephone. Expedited Appeal review requests can be made orally at 303-602-2261, or in writing at:

DHMP
ATTN: Grievance and Appeal Department
777 Bannock St., MC 6000
Denver, CO 80204-4507
Fax: (303) 602-2078

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

14. Information on Policy and Rate Changes

All commercial insurance policies offered by DHMP 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.

Amendment or Termination of this Plan

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

15. Definitions

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

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

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

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

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

A. FEDERALLY FUNDED TRIALS- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   i. The National Institutes of Health.
   ii. The Centers for Disease Control and Prevention.
   iii. The Agency for Health Care Research and Quality.
   iv. The Centers for Medicare & Medicaid Services.
   v. cooperative group or center of any of the entities described in clauses (i)through (iv) or the Department of Defense or the Department of Veterans Affairs.
   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
   vii. Any of the following if the conditions described in paragraph (2) are met:
      a. The Department of Veterans Affairs.
      b. The Department of Defense.
      c. The Department of Energy.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

A. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

B. assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

15. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

15. Definitions

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

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

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

Hospice Care: An alternative way of caring for terminally ill individuals that stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the patient. Hospice services include but are not necessarily limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

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

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

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

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

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

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

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

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

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

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

Observation Stay: A hospitalization lasting 23 hours or less.

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

Out-of-Pocket Maximum: The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy.

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

15. Definitions

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

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

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

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

Prior Authorization: If approved, provides an assurance by the Plan to pay for a medically necessary covered benefit provided by a designated provider for an eligible Plan member and is received prior to receiving a specific service, treatment or care. This process can be initiated by a provider, patient, or designated patient representative.

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.

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

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

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

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, and
6. 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 primary care provider to a network specialist or specialty treatment center in the DHMP network for illness or injury that requires ongoing care.

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

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

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.

15. Definitions

US Preventive Task Force (USPSTF) 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.

US Preventive Task Force (USPSTF) 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.

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.

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

ATTACHMENT A

Member Complaint and Appeal Form

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

Denver Health Medical Plan
Attn: Grievance and Appeal Department
938 Bannock St., Mail Code 6000
Denver, CO 80204-0606
Phone: 303-602-2261
Fax: 303-602-2078
www.denverhealthmedicalplan.org

www.denverhealthmedicalplan.org

DHMP Plan Type - Please check one:

- **DHA Medical Care (Plan A)** ☐
- **DHA Point of Service (POS)** ☐
- **HMO Expanded** ☐
- **CSA/DERP: HMO** ☐ ***or*** **DHMO** ☐
- **DPPA: HMO** ☐ ***or*** **DHMO** ☐
- **Elevate Silver: Basic** ☐ ***or*** **Expanded** ☐
- **Elevate Gold: Basic** ☐ ***or*** **Expanded** ☐

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

Last Name:	First Name:
Address:	City/State/Zip:
Telephone #:	Member ID#:
Date of Birth:	Medical Record #:

If other than Member listed above, please provide the following information for the person submitting the complaint or appeal. You must include a completed Designation of Personal Representative (DPR) Form with your request. Without this form, we will be unable to process your complaint or appeal. The DPR Form can be obtained by visiting our Web site or calling the telephone number provided above.

Name:	Telephone #:
Relationship to Member: Spouse ☐ Son/Daughter ☐ Parent/Legal Guardian ☐ Member's Provider ☐ Other ☐ (please specify) _____	
Mailing Address:	City/State/Zip:

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

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

Is this in regards to a denied claim? Yes ☐ No ☐ If Yes: Claim # _____ Date(s) of Service:_____ Provider Name:_____	Is this in regards to a denied medical service or treatment? Yes ☐ No ☐ If Yes, Please provide the date of the denial letter: _____

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

Member Signature:	Date:
Designated Personal Representative Signature:	Date:

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

Internal Use Only – Please do not write below this line

Receipt Date:_____ Complaint ☐ (or) Appeal ☐ Received By:_____

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

ATTACHMENT B

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, MC#6000
Denver, CO 80204
Phone: 303-602-2261 • Fax: 303-602-2094

ATTACHMENT C
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 D
Denver Health Medical Plan, Inc.

2014 HMO
Member Reimbursement Form

Member's Name:_____

Mailing Address: _____

Member's I.D. Number:_____

ORTHOTICS:

_____ L3000 $100.00
Maximum benefit per calendar year

HEARING AID:

_____V5100

$1500.00 every 5 years, if 18 years of age or older
Under age 18, covered at 100%

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

Mail Claims to: Denver Health Medical Plan
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992

16. Index

16. Index

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

YOU HAVE THE RIGHT TO DESIGNATE ANY PRIMARY CARE PROVIDER WHO PARTICIPATES IN OUR NETWORK AND WHO IS AVAILABLE TO ACCEPT YOU OR YOUR FAMILY MEMBERS. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Denver Health Medical Plan, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.org. The lifetime limit on the dollar value of benefits under Denver Health Medical Plan, Inc. no longer applies. Dependents may be covered up to the age of 26.

All DHMP 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.org

Form No. CSA_DERP 2014 HMO
Created on 11/26/13

2013 Colorado Health Benefit Plan Description Form
Denver Health Medical Plan, Inc.
Denver Health Medical Care
CSA and DERP Non-Medicare Primary

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

IMPORTANT NOTE: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the Member Handbook, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the Member Handbook to determine the exact terms and conditions of coverage. Copayment options reflect the amount the covered person will pay.

	In Network	Out-of- Network
4. DEDUCTIBLE TYPE[2]	Calendar year	N/A
4A. DEDUCTIBLE[2a] **a) [Individual] [Single][2b]** **b) [Family] [Non-single][2c]**	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
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **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
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	N/A
7A. 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
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes.	Not applicable

	In Network	Out-of-Network
8. MEDICAL OFFICE VISITS/ SERVICES[4] 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). 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
9. PREVENTIVE CARE SERVICES a) Children b) Adults	a) No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). b) No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). Lab, X-Ray or other preventive tests No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). $0 copay also includes all items on USPSTF preventive list Immunizations: No cost for injection only; if part of an office visit, office visit copay will apply to injection only; if part of an office visit, office visit copay will apply	Not covered
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care[5]	c. $25 Copayment per visit for In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. a) 20% coinsurance after Per Occurrence Deductible of $150 and Annual Deductible	Not covered

	In Network	Out-of-Network
11. PRESCRIPTION DRUGS[6] 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-formulary 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-formulary drugs (PA) 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-formulary drugs (PA) If prescription filled at a non-Denver Health Pharmacy (30-day supply): Tier 1: $40 copay Tier 2: $100 copay for brand name drugs Tier 3: $160 copay for non-formulary drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
12. INPATIENT HOSPITAL	20% after: Per Occurrence Deductible of $150 and Annual Deductible have been met (with a referral from your Primary Physician).	
12A. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES	20% after Deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% after Deductible has been met (with a referral from your Primary Physician).	Not covered
12B. CONGENITAL HEART DISEASE (CHD) SURGERIES	20% after Deductible has been met (with a referral from your Primary Physician).	Not covered
13. OUTPATIENT/AMBULATORY SURGERY	20% after: Per Occurrence Deductible of $75 and Annual Deductible have been met (with a referral from your Primary Physician).	
13A. SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC	20% after Deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% after Deductible has been met (with a referral from your Primary Physician). Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, or Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Category.	
13B. RECONSTRUCTIVE PROCEDURES	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
14. 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.	

	In Network	Out-of-Network
15. EMERGENCY CARE[7, 8]	$300 Copayment per visit.	$150 copay per visit (waived if admitted)
15A. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
16. AMBULANCE	Ground Transportation: 20% after Deductible has been met. Air Transportation: 20% after Deductible has been met.	$450 copay per trip (not waived if admitted)
17. 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.	$100 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	 a) 20% after Deductible has been met. b) $50 Copayment per visit.	
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 above as a mental disorder)	Inpatient care: 20% after Deductible has been met. Outpatient care: $50 Copayment per visit.	Not covered
21. 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
21A. 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.	
21B. REHABILITATION SERVICES – OUTPATIENT THERAPY (CONGENITAL DEFECTS AND BIRTH ABNORMALITIES)	$25 Copayment per visit. Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	
21C. THERAPEUTIC TREATMENTS - OUTPATIENT	20% after Deductible has been met. Therapeutic treatments include, but are not limited to: Dialysis, intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.	
21D. CLINICAL TRIALS	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary	

	In Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	20% after Deductible has been met. Benefits are limited to $2,500 per calendar year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	Not covered
22A. DIABETES SERVICES	Diabetes Self Management and Training. Diabetic Eye Examinations / Foot Care Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Diabetes Self Management Items	
22B. OSTOMY SUPPLIES	20% after Deductible has been met. Benefits for Ostomy Supplies are limited to $2,500 per calendar year.	
22C. PROSTHETIC DEVICES	20% after Deductible has been met. Benefits for Prosthetic Devices are limited to $2,500 per calendar year. This limit does not apply to prosthetic arms, legs, feet and hands. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	
22D. HEARING AIDS FOR ADULTS	20% after Deductible has been met. Benefits for Hearing Aids are limited to $2,500 per calendar year.Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	
23. OXYGEN	Included under Durable Medical Equipment.	
24. ORGAN TRANSPLANTS Depending upon where the Covered Health Service is provided,	Benefits will be the same as those stated under each Covered Health Services category in this Benefit Summary. For In-Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants	
25. HOME HEALTH CARE	20% after Deductible has been met. Benefits are limited to 60 visits for skilled care services per calendar year.	
26. HOSPICE CARE	20% after Deductible has been met. Bereavement support services are limited to a maximum of $1,400 during the 12-month period following the Covered Person's death.	
27. SKILLED NURSING FACILITY CARE	20% after Deductible has been met. Benefits are limited to 60 days per calendar year.	
28. 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.	

	In Network	Out-of-Network
29. VISION CARE	$25 Copayment per visit. Benefits are limited to 1 exam every 2 calendar years.	Not covered
30. CHIROPRACTIC CARE	$50 Copayment per visit for Manipulative Treatment (provided with a referral from your Primary Physician). Benefits are limited to 20 visits per calendar year.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES 1) CHILDREN'S DENTAL ANESTHESIA 2) CLEFT LIP AND CLEFT PALATE 3) TELEMEDICINE 4) PHENYLKETONURIA (PKU) TESTING AND TREATMENT 5) HEARING AIDS (MINOR CHILDREN)	1) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 2) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 3) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 4) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 5) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. • **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

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	Not applicable; plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions available immediately upon request or see Section 4 in the Member Handbook. Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	In Network	Out-of-Network
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
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	
39. What is the main customer service number?	303-602-2100 or 800-700-8140	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	DHMP-Member Complaint Coordinator 777 Bannock St., MC 6000 Denver, CO 80204 303-602-2100 or 800-700-8140	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202 E-mail: Insurance@dora.state.co.us Fax: 303-894-7455	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	COM_MKT_101-00	
43. Does the plan have a binding arbitration clause?	No	

Endnotes

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

2 "Deductible type" indicates whether the Deductible period is "Calendar Year" (Jan 1 – Dec 31) or "Benefit Year" (i.e. based on a benefit year beginning on the policy's anniversary date) or if the Deductible is based on other requirements such as "Per Accident or Injury" or "Per Confinement."

2A A "Deductible" means the amount that you will have to pay for the allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

2B "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

2C "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA-qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any benefits are paid.

3 "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

4 Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness and mental disorders as defined in Endnote number 9 below.

5 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together; there are not separate copayments, unless mother and baby are discharged separately.

6 Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

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

8 Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific 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.

10 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

11 Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of these procedures.

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.

DENVER HEALTH Medical Plan, Inc.

Career Service Authority / Denver Employee Retirement Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for:
Individual | Plan Type: DHMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** per year for an individual. Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for the covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes. **$150** for delivery & inpatient well baby care. **$150** for inpatient care. **$75** outpatient/ ambulatory surgery.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** per year for an individual.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

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OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$50 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$50 copay per visit for chiropractor	Not covered	$50/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after Deductible has been met.	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$150 copay per service.	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	**Discount Generic (30 day supply)** Denver Health Pharmacy $12 copay Non Denver Health Pharmacy $20 copay **Generic (30 day supply)** Denver Health Pharmacy $12 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $40 copay Non Denver Health Pharmacy (30 day) $50 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $50 copay Non Denver Health Pharmacy (30 day) $80	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $50 copay Non Denver Health Pharmacy (30 day) $80	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after: per occurrence deductible of $75 and annual deductible have been met.	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	20% coinsurance after deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% coinsurance after deductible has been met (with a referral from your Primary Physician).	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$300 copay per visit.	$300 copay per visit.	waived if admitted
	Emergency medical transportation	20% coinsurance after deductible has been met.	20% coinsurance after deductible has been met.	-------none--------
	Urgent care	$75 copay per visit	$75 copay per visit	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per stay	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	20% coinsurance after deductible has been met.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$50 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	20% coinsurance after deductible has been met.	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit	Not covered	-------none--------
	Delivery and all inpatient services	20% coinsurance after per occurrence deductible of $150 and annual deductible	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible has been met.	Not covered	60 visits/year Pre-Authorization required for Plan to pay
	Rehabilitation services	$25 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$25 copay per visit.	Not covered	Congenital defect and birth abnormalities for children from age 3-6 are covered 20 visits per therapy/year
	Skilled nursing care	20% coinsurance after deductible has been met.	Not covered	60 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	20% coinsurance after deductible has been met.	Not covered	$2,500 per year. Pre-Authorization required for Plan to pay
	Hospice service	20% coinsurance after deductible has been met.		$1,400 maximum bereavement support. Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$25 copay per visit	1 eye exam per 2 calendar years.	-------none--------
	Glasses	Not covered	---------none---------	-------none--------
	Dental check-up	ACCIDENTAL ONLY 20% after deductible has been met. Fluoride treatments by PCP for children are covered.	Not covered	$3,000 maximum per calendar year. $900 maximum per tooth.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, the, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Denver Health Medical Plan grievance department at 303-602-2261 or by fax at 303-602-2078.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $5,820**
- **Patient pays $ 1,720**

Sample Care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$650
Copays	$20
Coinsurance	$900
Limits or exclusions	$150
Total	$1,720

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $$3,870**
- **Patient pays $1,530**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$500
Copays	$710
Coinsurance	$240
Limits or exclusions	$80
Total	$1,530

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

DENVER HEALTH Medical Plan, Inc.

Career Service Authority / Denver Employee Retirement Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for:
Individual and Spouse | Plan Type: DHMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** per year for an individual. **$1500** per year for a family. Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for the covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes. **$150** for delivery & inpatient well baby care. **$150** for inpatient care. **$75** outpatient/ ambulatory surgery.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** per year for an individual. **$5,000** per year for a family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

Form No.: COM_MKT_144-00
Creation/Rev Date 12/27/12
OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$50 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$50 copay per visit for chiropractor	Not covered	$50/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after Deductible has been met.	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$150 copay per service.	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	**Discount Generic (30 day supply)** Denver Health Pharmacy $12 copay Non Denver Health Pharmacy $20 copay **Generic (30 day supply)** Denver Health Pharmacy $12 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $40 copay Non Denver Health Pharmacy (30 day) $50 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $50 copay Non Denver Health Pharmacy (30 day) $80	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $50 copay Non Denver Health Pharmacy (30 day) $80	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after: per occurrence deductible of $75 and annual deductible have been met.	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	20% coinsurance after deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% coinsurance after deductible has been met (with a referral from your Primary Physician).	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$300 copay per visit.	$300 copay per visit.	waived if admitted
	Emergency medical transportation	20% coinsurance after deductible has been met.	20% coinsurance after deductible has been met.	-------none--------
	Urgent care	$75 copay per visit	$75 copay per visit	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per stay	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	20% coinsurance after deductible has been met.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$50 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	20% coinsurance after deductible has been met.	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit	Not covered	-------none--------
	Delivery and all inpatient services	20% coinsurance after per occurrence deductible of $150 and annual deductible	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible has been met.	Not covered	60 visits/year Pre-Authorization required for Plan to pay
	Rehabilitation services	$25 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$25 copay per visit.	Not covered	Congenital defect and birth abnormalities for children from age 3-6 are covered 20 visits per therapy/year
	Skilled nursing care	20% coinsurance after deductible has been met.	Not covered	60 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	20% coinsurance after deductible has been met.	Not covered	$2,500 per year. Pre-Authorization required for Plan to pay
	Hospice service	20% coinsurance after deductible has been met.		$1,400 maximum bereavement support. Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$25 copay per visit	1 eye exam per 2 calendar years.	-------none--------
	Glasses	Not covered	---------none---------	-------none--------
	Dental check-up	ACCIDENTAL ONLY 20% after deductible has been met. Fluoride treatments by PCP for children are covered.	Not covered	$3,000 maximum per calendar year. $900 maximum per tooth.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

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If you lose coverage under the plan, the, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $5,820**
- **Patient pays $ 1,720**

Sample Care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$650
Copays	$20
Coinsurance	$900
Limits or exclusions	$150
Total	$1,720

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $$3,870**
- **Patient pays $1,530**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$500
Copays	$710
Coinsurance	$240
Limits or exclusions	$80
Total	$1,530

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

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Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.DenverHealthMedicalPlan.com or by calling 1-800-700-8140.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** per year for an individual. **$1500** per year for a family. Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for the covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Yes. **$150** for delivery & inpatient well baby care. **$150** for inpatient care. **$75** outpatient/ ambulatory surgery.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** per year for an individual. **$5,000** per year for a family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Copayments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers see www.DenverHealthMedicalPlan.com or call 303-602-2100.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, members must have a referral from their PCP except for emergency care, outpatient mental health, chiropractic, routine eye care, and OB-GYN care.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-700-8140 or visit us at **www.DenverHealthMedicalPlan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **http://www.denverhealthmedicalplan.com/career-service-authorityderp-non-medicare-primary-.aspx** or call 1-800-700-8140 to request a copy.

Form No.: COM_MKT_142-00
Creation/Rev Date 12/27/12
OMB Conrol Numbers 1545-2229
1210-0147, and 0938-1146

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan requires you to use in-network **providers.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	Not covered	-------none--------
	Specialist visit	$50 copay per visit	Not covered	Written referral required
	Other practitioner office visit	$50 copay per visit for chiropractor	Not covered	$50/visit and 20 visits per year.
	Preventive care/screening/ immunization	No charge	Not covered	-------none--------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after Deductible has been met.	Not covered	-------none--------
	Imaging (CT/PET scans, MRIs)	$150 copay per service.	Not covered	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.DenverHealthMedicalPlan.com	Generic drugs	**Discount Generic (30 day supply)** Denver Health Pharmacy $12 copay Non Denver Health Pharmacy $20 copay **Generic (30 day supply)** Denver Health Pharmacy $12 copay Non Denver Health Pharmacy $20 copay	Not covered	-------none--------
	Preferred brand drugs	Denver Health Pharmacy (30 day) $40 copay Non Denver Health Pharmacy (30 day) $50 copay	Not covered	-------none--------
	Non-preferred brand drugs	Denver Health Pharmacy (30 day) $50 copay Non Denver Health Pharmacy (30 day) $80	Not covered	-------none--------
	Specialty drugs	Denver Health Pharmacy (30 day) $50 copay Non Denver Health Pharmacy (30 day) $80	Not covered	-------none--------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after: per occurrence deductible of $75 and annual deductible have been met.	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fees	20% coinsurance after deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% coinsurance after deductible has been met (with a referral from your Primary Physician).	Not applicable	-------none--------
If you need immediate medical attention	Emergency room services	$300 copay per visit.	$300 copay per visit.	waived if admitted
	Emergency medical transportation	20% coinsurance after deductible has been met.	20% coinsurance after deductible has been met.	-------none--------
	Urgent care	$75 copay per visit	$75 copay per visit	-------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per stay	Not covered	Pre-Authorization required for Plan to pay
	Physician/surgeon fee	Not applicable	Not covered	-------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copay per visit	Not covered	-------none--------
	Mental/Behavioral health inpatient services	20% coinsurance after deductible has been met.	Not covered	Pre-Authorization required for Plan to pay
	Substance use disorder outpatient services	$50 copay per visit	Not covered	-------none--------
	Substance use disorder inpatient services	20% coinsurance after deductible has been met.	Not covered	Pre-Authorization required for Plan to pay
If you are pregnant	Prenatal and postnatal care	$25 copay per visit	Not covered	-------none--------
	Delivery and all inpatient services	20% coinsurance after per occurrence deductible of $150 and annual deductible	Not covered	Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible has been met.	Not covered	60 visits/year Pre-Authorization required for Plan to pay
	Rehabilitation services	$25 copay per visit.	Not covered	20 visits/year per type of therapy.
	Habilitation services	$25 copay per visit.	Not covered	Congenital defect and birth abnormalities for children from age 3-6 are covered 20 visits per therapy/year
	Skilled nursing care	20% coinsurance after deductible has been met.	Not covered	60 days/year Pre-Authorization required for Plan to pay
	Durable medical equipment	20% coinsurance after deductible has been met.	Not covered	$2,500 per year. Pre-Authorization required for Plan to pay
	Hospice service	20% coinsurance after deductible has been met.		$1,400 maximum bereavement support. Pre-Authorization required for Plan to pay

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$25 copay per visit	1 eye exam per 2 calendar years.	-------none--------
	Glasses	Not covered	---------none---------	-------none--------
	Dental check-up	ACCIDENTAL ONLY 20% after deductible has been met. Fluoride treatments by PCP for children are covered.	Not covered	$3,000 maximum per calendar year. $900 maximum per tooth.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Cosmetic surgery • Dental care (Adult) • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S • Private-duty nursing	• Routine eye care (Adult) • Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery	• Chiropractic care	• Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, the, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-700-8140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Denver Health Medical Plan grievance department at 303-602-2261 or by fax at 303-602-2078.

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays $5,820**
- **Patient pays $ 1,720**

Sample Care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient Pays:

Deductibles	$650
Copays	$20
Coinsurance	$900
Limits or exclusions	$150
Total	$1,720

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays $$3,870**
- **Patient pays $1,530**

Sample Care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient Pays:

Deductibles	$500
Copays	$710
Coinsurance	$240
Limits or exclusions	$80
Total	$1,530

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums.**
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Member Handbook 2014

DENVER HEALTH
Medical Plan, Inc.

Career Services Authority (CSA)
and Denver Employee Retirement Plan (DERP)
Non-Medicare Primary Denver Medical Care

DHMO

1. Schedule of Benefits (Who Pays What)

	In Network	Out of Network
Annual Deductible		
Individual Family	■ $500 per year ■ $1,500 per year • 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 in addition to the Annual Deductible.	Not applicable.
Annual Out of Pocket Maximum		
Individual Family	■ $2,500 per year ■ $5,000 per year • The Deductible is included in the Out-of-Pocket Maximum. • 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 accumulate towards the Out-of-Pocket Maximum.	Not applicable.
Lifetime maximum		
	■ No lifetime maximum	Not applicable.
Covered Providers		
	■ Denver Health and Hospital Authority providers and Denver Health Medical Center. Columbine network for chiropractic. See provider directory for a complete list of current providers.	Not applicable.
Medical Office Visits		
Primary care providers (Family Medicine, Internal Medicine and Pediatrics)	■ $25 copay per visit ■ In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies for additional services.	Not covered.
Specialist	■ $50 copay per visit	Not covered.
Preventive Services		
Children Adults	■ No copayment (100% covered) Including but not limited to annual well visit, well woman exams, prenatal and post partum visits; colonoscopy, mammogram. For entire list see USPSTF list on our website at www.denverhealthmedicalplan.org	Not covered.
Maternity		
Prenatal Care Delivery, Inpatient and Well Baby Care	■ $0 copay per visit ■ 20% coinsurance after Per Occurrence Deductible of $150 and Annual Deductible	Not covered.

1. Schedule of Benefits (Who Pays What)

Prescription Drugs		
	Denver Health Pharmacy (30-day supply) ■ Discount: $4 copay ■ Generic: $12 copay ■ Preferred Brand: $40 copay ■ Non-preferred Brand: $50 copay Denver Health Pharmacy or Denver Health Pharmacy by Mail (90-day supply) ■ Discount: $8 copay ■ Generic: $24 copay ■ Preferred Brand: $80 copay ■ Non-preferred Brand: $100 copay Non-Denver Health Pharmacy (30-day supply) ■ Discount: $8 copay ■ Generic: $20 copay ■ Preferred Brand: $50 copay ■ Non-preferred Brand: $80 copay (PA) Non-Denver Health Pharmacy (90-day supply) ■ Discount: $16 copay ■ Generic: $40 copay ■ Preferred Brand: $100 copay ■ Non-preferred Brand: $160 (PA) For drugs on our approved list, call Member Services at (303) 602-2100.	Not covered.
Inpatient Hospital		
	■ 20% after Per Occurrence Deductible of $150 and Annual Deductible have been met ■ Preauthorization required Maximum on surgical treatment of morbid obesity of once per lifetime.	Not covered.
Outpatient/Ambulatory Surgery		
	■ 20% after Per Occurrence Deductible of $75 and Annual Deductible have been met ■ Preauthorization required	Not covered.
Diagnostics Laboratory and Radiology		
Laboratory, X-ray and CT MRI and PET scans	■ 20% after Deductible has been met ■ $150 copay per test	Not covered.
Other Diagnostic and Therapeutic Services		
Sleep study	■ 20% after Deductible has been met	Not covered.
Radiation therapy	■ 20% after Deductible has been met	
Infusion therapy (includes chemotherapy)	■ 20% after Deductible has been met	
Injections	■ 20% after Deductible has been met (immunizations, allergy shots and any other injection given by a nurse is a $0 copay)	
Renal Dialysis	■ Covered at 100%	
Emergency Care		
	■ $300 copay per visit	■ $300 copay (deductible and coinsurance do not apply)

1. Schedule of Benefits (Who Pays What)

Urgent Care		
	■ $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	■ $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
Ambulance		
	■ Ground Transportation: 20% after Deductible has been met. ■ Air Transportation: 20% after Deductible has been met	■ Ground Transportation: 20% after Deductible has been met. ■ Air Transportation: 20% after Deductible has been met
Behavioral Health, Mental Health Care and Substance Abuse		
Outpatient:	■ $50 copay per visit	Not covered.
Inpatient:	■ 20% after Per Occurrence Deductible of $150 and Annual Deductible have been met ■ Members can self refer to a Cofinity provider for mental health and substance abuse. ■ Preauthorization required	Not covered.
Therapies		
Rehabilitative: Physical, Occupational, and Speech Therapy	■ $25 copay per visit ■ 20 of each therapy per calendar year	Not covered.
Habilitative: Physical, Occupational, and Speech Therapy	■ $25 copay per visit ■ $20 of each therapy per calendar year ■ Preauthorization Required	Not covered.
Pulmonary Rehabilitation	■ $25 copay per visit ■ 20 of each therapy per calendar year	Not covered.
Cardiac Rehabilitation	■ $25 copay per visit ■ 36 of each therapy per calendar year	Not covered.
Durable Medical Equipment		
	■ 20% coinsurance applies; maximum benefit is $2,500 per calendar year ■ Preauthorization required	Not covered.
Hearing Aids		
Adults	■ Medically-necessary hearing aids prescribed by a DHMP Medical Care Network provider are covered every five years in network. For adults age over 18, there is a $2,500 benefit maximum every 5 years. Charges exceeding the $2,500 hearing aid maximum benefit, are the responsibility of the member. ■ Cochlear implants are now covered. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply.	Not covered.
Children	■ 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 no longer apply to the annual DME limit. ■ Cochlear implants are now covered. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply. ■ Preauthorization required	Not covered.

1. Schedule of Benefits (Who Pays What)

Prosthetics		
	■ 20% coinsurance applies; no maximum benefit, does not apply to DME maximum. ■ Preauthorization required	Not covered.
Orthotics		
	Medically necessary orthotics are reimbursed up to $100 per calendar year	Not covered.
Oxygen/Oxygen Equipment		
Oxygen	■ 100% Covered. ■ Preauthorization required	Not covered.
Equipment	■ 20% coinsurance applies; no maximum benefit, does not apply to DME maximum. ■ Preauthorization required	Not covered.
Organ Transplants		
	■ $20% after Per Occurrence Deductible of $150 and Annual Deductible have been met. 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. ■ Preauthorization required.	Not covered.
Home Health Care		
	■ No copay (100% covered) for prescribed medically necessary skilled home health services. ■ Preauthorization required.	Not covered.
Hospice Care		
	■ 20% after Deductible has been met. Bereavement support services are limited to a maximum of $1,400 during the 12-month period following the Covered Person's death. ■ Preauthorization required.	Not covered.
Skilled Nursing Facility		
	■ 20% after Deductible has been met. Benefits are limited to 60 visits per calendar year. ■ Preauthorization required.	Not covered.
Dental Care		
	Not covered except for fluoride varnish at PCP visit.	Not covered.
Vision Care		
	■ $25 Copayment per visit. Benefits are limited to 1 exam every 24 months	Not covered.

1. Schedule of Benefits (Who Pays What)

Chiropractic		
	■ $50 copay per visit. Maximum 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	
	Note: Massage therapy is not a plan benefit but DHMP offers a discount program through Columbine Chiropractic. Many chiropractic offices offer massage therapy as well. DHMP will not pay for massage therapy received at a Columbine Chiropractic office. Member must pay through discount program.	
Additional Benefits		
	■ 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! ■ 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 ■ eLearning module for parents-to-be. Online childbirth classes, free of charge to members. ■ Take Control of Your Health incentive plan	

Prior Authorization is required for, but not limited to, the following services: Durable medical equipment, genetic testing, home health care (including home infusion therapy); all hospital stays (including mental health or substance abuse-related stays), outpatient surgery (except those procedures performed in a physician's office), reconstructive surgery, non-formulary medications, skilled nursing facility care, transplant evaluations and hospice care, cochlear implants, clinical trials or study. Contact your primary care provider to request these services and provide the medical necessity information.

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

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

2. Title Page (Cover Page)

January 2014

The information contained in this Member Handbook explains the administration of the benefits of Denver Health Medical Plan (DHMP). DHMP is a health insurance plan offered by Denver Health Medical Plan, Inc., a state-licensed health maintenance organization (HMO). This Member Handbook is also considered your Evidence of Coverage document. Information regarding the administration of DHMP benefits can also be obtained through marketing materials, by contacting the Member Services Department at 303-602-2100 or toll-free at 1-800-700-8140 and on our web site at www.denverhealthmedicalplan.org. In the event of a conflict between the terms and conditions of this Member Handbook and any supplements to it and any other materials provided by DHMP, the terms and conditions of this Member Handbook and its supplements will control.

Coverage as described in this Member Handbook commences January 1, 2014 and ends December 31, 2014.

3. Contact Us

Member Services 303-602-2100 • Fax 303-602-2138

- Benefit questions
- Eligibility questions
- Billing questions
- Transportation (help schedule rides to and from appointments)
- Grievances (complaints)

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

- Pharmacy prior authorizations (medications that are not covered)
- Pharmacy claim rejections
- Medication cost
- Medication safety

Care Support Services 303-602-2080

- Learn how to navigate the health care system
- Get the most out of your health care plan
- Answer questions about DHMP's programs and services

Utilization Management 303-602-2140 • Fax 303-602-2128

- Authorization questions

Denver Health Appointment Center • 303-436-4949

24 Hour NurseLine • 303-739-1261

4. Table of Contents

5. Eligibility

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 primary 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, civil union or same sex domestic partner);
- A child married or unmarried until their 26th birthday as long as they are not eligible for health care benefits through their employer
- An unmarried child of any age who is medically certified as disabled and dependent upon you.

A child, meeting the age limitations above, may be a dependent whether the child is your biological child, your stepchild, your 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 may be eligible for care through our national network. For more information, call 303-602-2100.

For a common-law spouse, civil union or same sex domestic partner, you must complete the appropriate paperwork (affidavit). Contact your employer.

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, gender, 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.

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 toll free at 1-800-700-8140 (TTY/TTD users should call 303-602-2129 or toll free at 1-866-538-5288).

5. Eligibility

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.

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.

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.

5. Eligibility

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 at 303-602-2100 or toll free at 1-800-700-8140 (TTY/TTD users should call 303-602-2129 or toll free at 1-866-538-5288) 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 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.

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 Your Services and Obtain Approval of Benefits

Welcome to Denver Health Medical Plan

At DHMP our main concern is that you receive quality health care services.

As a member of DHMP you must receive your health care services within the contracted network.

Please see the Summary of Benefits for a breakdown of cost sharing.

Your Primary Care Provider

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

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

Selecting a Primary Care Provider

To find primary care providers that participate in the DHMP network, visit www.denverhealthmedicalplan.org and select "Find A Doctor/Provider." You may also contact Member Services at 303-602-2100 or toll-free at 1-855-700-8140 (TTY/TDD users should call 303-602-2129 or toll-free at 1-866-538-5288)

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

Changing Your Primary Care Provider

If you decide to select a new primary care provider, there is no need to tell us. You can change your selection at any time. Our web site provides the most up-to-date information on providers that participate in the DHMP network. Or call Member Services at 303-602-2100 if you need more information.

Specialty Care

If you think you need to see a specialist or other provider, you should contact your primary care provider. He/she will work with you to determine if you need to see a specialist, provide you with a referral, and help to coordinate your care.

Members may self refer for the following services: OB/GYN, Behavioral Health, and routine eye care.

Your Health Network

The DHMP Basic network is made up of all Denver Health clinics and facilities. This includes 8 community health centers, 15 school-based health centers and the main Denver Health Medical Center campus. The main campus includes the Webb Primary Care Center for outpatient care as well as the inpatient hospital facility.

To find a full list of DHMP network providers, visit www.denverhealthmedicalplan.org and click on Find a Doctor/Provider for our web based provider directory, or call Member Services at 303-602-2100.

If you need a service that is not offered by Denver Health Medical Center or you cannot get an appointment in a timely manner, you can be referred to a provider outside this network. However, you must have prior authorization for DHMP to pay for the services. If you have questions regarding this, call Member Services at 303-602-2100.

After Hours Care

Medical care after hours is covered. If you have an urgent medical need, you may visit any urgent care center that is convenient for you. You may also call the NurseLine 24 hours/day, 7 days/week at 303-739-1261. If you have a life or limb-threatening emergency, go to the closest emergency room or dial 9-1-1. No authorization is necessary.

Emergency Care

Emergencies are life-threatening conditions or symptoms that arise suddenly and unexpectedly. These symptoms are so severe that you need medical attention now to prevent loss of life or limb. If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. There is no need for prior authorization.

Care Outside the Health Plan Network:

Care outside of the DHMP network may be covered if:

1. The type of care is not provided within the DHMP network, and
2. You receive a referral from your primary care provider or specialist, and
3. The referral is approved (authorized), in advance, by Utilization Management.

If you choose to see a provider who is not a participating provider without a referral from your primary care provider and/or 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.

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

Authorization Process

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

The following are examples of services that require approval before receiving the service (prior authorization):

- Hospital admissions (including mental health, inpatient rehabilitation, and substance abuse admissions).
- Outpatient surgery (except those procedures performed in a physician's office)
- Genetic testing
- Cochlear implants for children under age 18
- Coverage for services in a clinical trial or study
- Home health care (including home infusion therapy)
- Durable medical equipment
- Skilled nursing facility admissions
- Hospice care
- Transplant evaluations/procedures
- Referral to out-of-network specialists or facilities
- Urgent/emergent care admissions do not require prior authorization but will be reviewed concurrently.

Utilization Management staff is available to answer UM questions Monday through Friday, from 8:00 AM to 5:00 PM, except on holidays. If you have questions or concerns about the authorization process, specific cases, or UM decisions, please call us at 303-602-2140 or toll-free, 1-855-700-8140. A TTY/TDD line is available for the hearing- or speech-impaired at 303-602-2129. We also have bilingual staff and language assistance services available at no charge.

Nurse Line

DHMP members can call the Denver Health NurseLine 24 hours a day/7 days a week at 303-739-1261. This service is staffed by nurses trained to answer your questions. In some cases the Nurse Line representative can call in a prescription and save you a trip to urgent care.

Language Line Services

DHMP is committed to meeting our plan members' needs. DHMP contracts with Language Line Services, Inc. to provide translation services at no cost to our plan members. If you need an interpreter during your clinic visit, please tell the Appointment Center representative when you make your appointment. For further assistance, please contact Member Services at 303-602-2100 or toll-free at 1-855-700-8140. Our TTY/TDD number is 303-602-2129.

Access Plan

Denver Health Medical Plan has an Access Plan that evaluates all physicians, hospitals and other providers in the network to assure members have adequate access to services. This plan also explains DHMP's referral, coordination of care, and emergency coverage procedures. You may make an appointment to review the Access Plan on site at DHMP's offices, by calling Member Services at 303-602-2100 or toll-free at 1-855-700-8140.

When You Are Out of Town

When you are traveling, you may go to any hospital or urgent care center that is convenient for you. If you need emergency care, go to the nearest hospital or call 9-1-1. Following an emergency or urgent care visit out of network, one follow up visit is covered if you cannot reasonably travel back to your service area. Travel expenses back to the DHMP network are not a covered benefit. If you plan to be outside the DHMP service area and need your prescription filled, we have many network pharmacies across the country that you may use. Please check with Member Services at 303-602-2100 or toll-free at 1-855-700-8140 (TTY/TDD users should call 303-602-2100 or toll-free at 1-866-538-5288).

If you are a dependent residing, attending school or traveling outside of the Denver Health Medical Plan service area, you can call Member Services at 303-602-2100 for assistance in finding a network provider. Prescriptions are covered when filled at a network pharmacy, DHMP has a national prescription network. When urgent care or emergency services are needed, visit the closest facility or call 9-1-1.

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

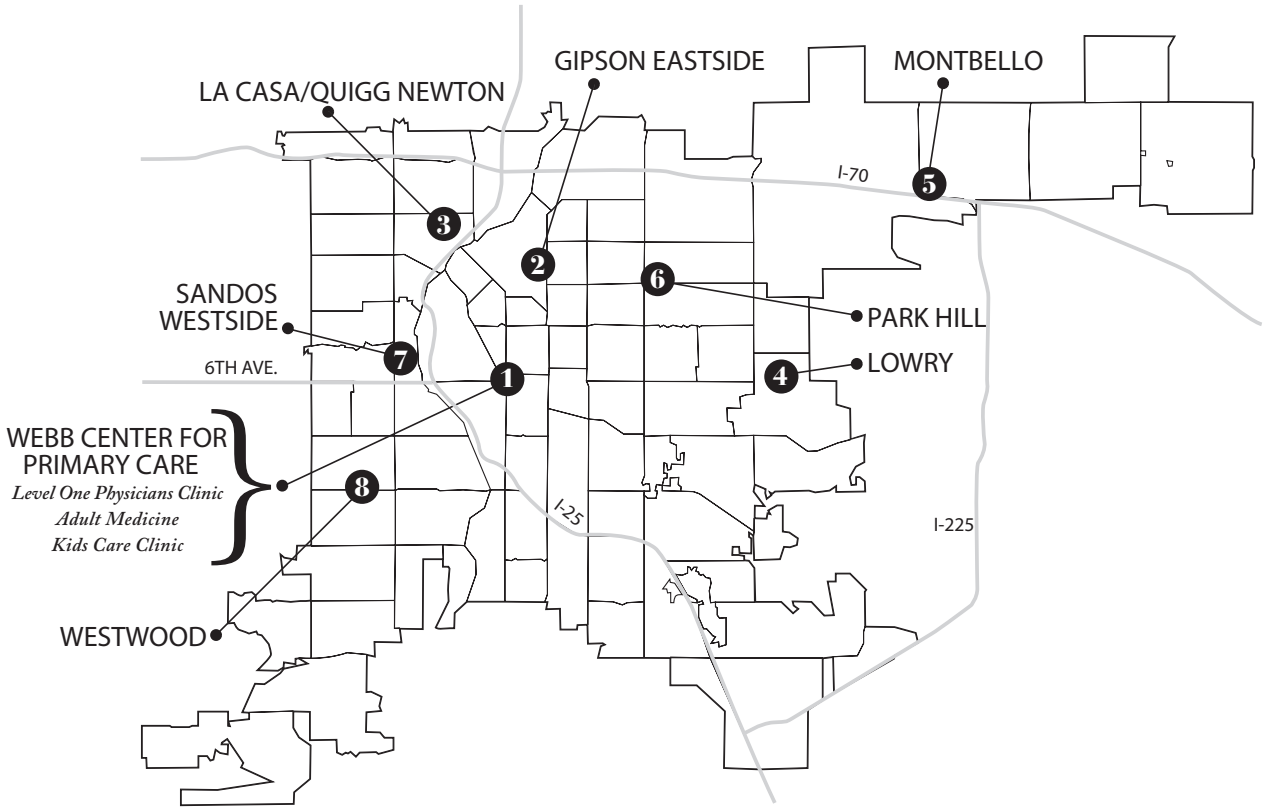
Change of Address

If you change your name, mailing address, or telephone number, contact your benefits manager.

Advance Directives

Advance directives are written instructions concerning your wishes about your medical treatment. These are important health care decisions and they deserve careful thought. Advance Directive decisions include the right to consent to (accept) or refuse any medical care or treatment, and the right to give advance directives. It may be a good idea to discuss them with your doctor, family, friends, or staff members at your health care facility, and even a lawyer. You can obtain more information about advance directives, such as living wills, medical durable powers of attorney, and CPR directives (do not resuscitate orders) from your primary care provider, 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.org.

Map of Denver Health Family Health Centers



FAMILY HEALTH CENTERS

1 ℞ **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
PHARMACY	303.602.8500

2 ℞ **GIPSON EASTSIDE**

501 28th St.	303.436.4600
Pharmacy	303.436.4600

3 ℞ **LA CASA/QUIGG NEWTON**

4545 Navajo	303.602.6700
Pharmacy	303.602.6700

4 **LOWRY**

1001 Yosemite St.	303.602.4545
Suite 100	

5 ℞ **MONTBELLO**

12600 E. Albrook Dr.	303.602.4000
Pharmacy	303.602.4025

6 **PARK HILL**

4995 E. 33rd Ave.	303.602.3720

7 ℞ **SANDOS WESTSIDE**

1100 Federal Blvd	303.436.4200
Pharmacy	303.436.4200

8 **WESTWOOD**

4320 W Alaska Ave	303.602.4660

1 **HOSPITAL**

DENVER HEALTH MEDICAL CENTER

777 Bannock St.	303.436.6000

ADULT URGENT CARE WALK-IN CLINIC

777 Bannock St.	303.602.2822

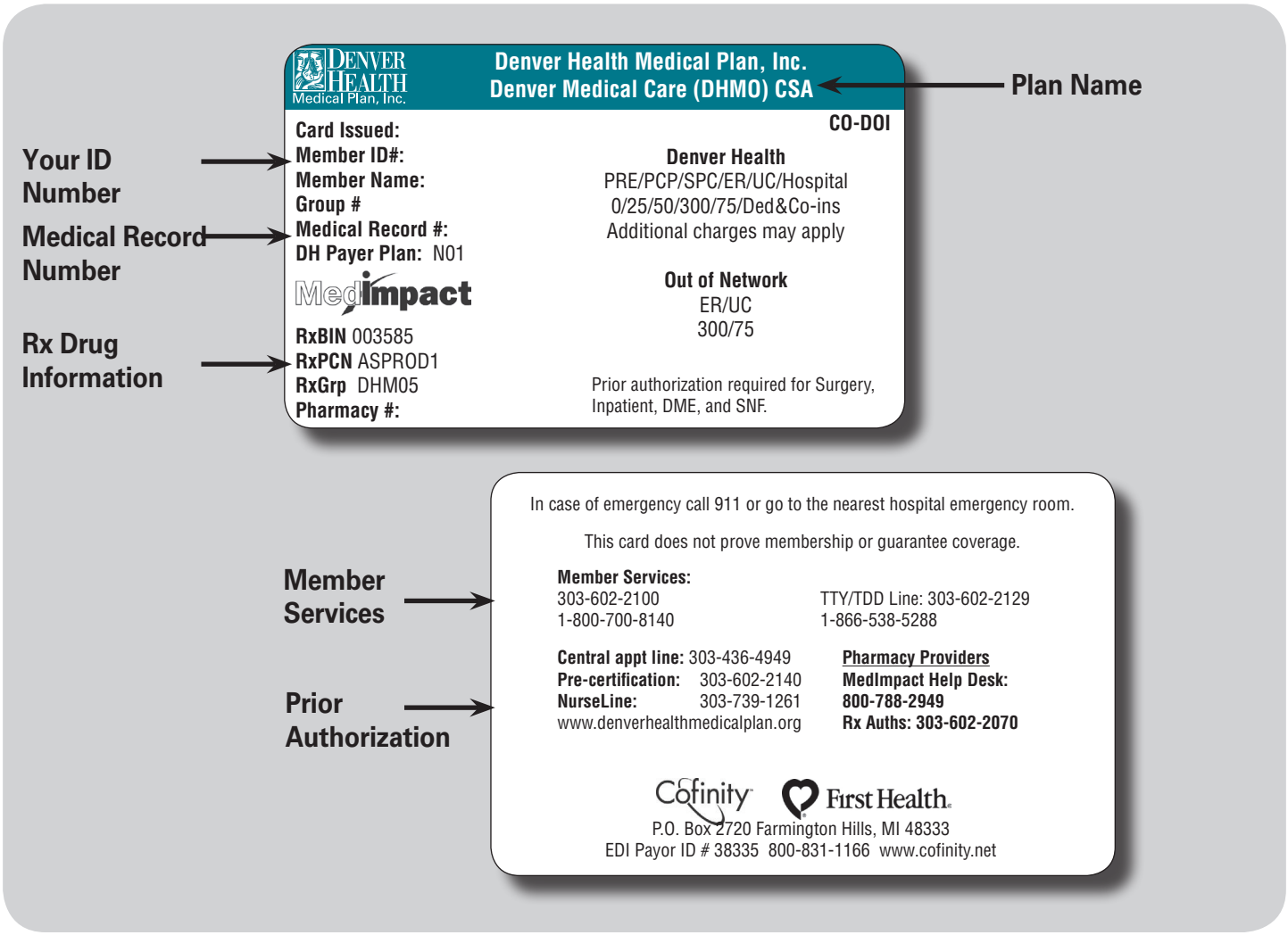
PEDIATRIC URGENT CARE CLINIC

777 Bannock St.	303.602.3300

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

Your Denver Health Medical Plan Identification Card

Keep your DHMP identification card with you at all times. Before receiving medical or prescription services, you must show your DHMP identification card. If you fail to do so, or misrepresent your membership status, claims payment may be denied. If you lose your identification card and need a new one, call Member Services at 303-602-2100 or toll-free at 1-855-700-8140 Monday — Friday 8 a.m. — 5 p.m. (TTY/TDD users should call 303-602-2129 or toll-free at 1-866-538-5288)



Member Newsletter

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

Complex Case Management (CCM)

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

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

Complex Case Managers are available to:

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

Our goal is to assist you to:

- Regain and/or improve health or function
- Better understand your health conditions and concerns
- Understand your health care benefits and get the care you need
- Take a more active role in your care and treatment plan

Members or their caregivers may self-refer to gain access to these voluntary services. Complex Case Management services are provided at no cost to you and will not affect your plan benefits.

To participate in a Complex Case Management Program or to learn more about Complex Case Management, please call Care Support Services at 303-602-2080. You can also obtain more information about program eligibility and services at www.denverhealthmedicalplan.org.

Behavioral Health and Wellness Services

As a DHMP member, you have access to many services offered through our Behavioral Health and Wellness Services Department. Our Health Coaches can help you take a more active role in your health care by helping you enroll in an exercise program, eat better/lose weight, stop smoking, lower stress, take your medications, and manage chronic diseases like diabetes. We also offer monthly health and wellness talks as well as weekly education classes on health-related topics. Sometimes people feel stressed, worried, or depressed. The good news is that there are many things we can do to feel better. As a member, you can work with a counselor over the phone to learn new ways to deal with depression, anxiety and related problems. All of these services are no cost to you! To learn more or to sign up for any of these programs, please call Care Support Services at 303-602-2080 or toll-free at 1-855-700-8140 For TTY/TDD call 303-602-2129.

Your Benefits

It is important that you understand the benefits and cost sharing that apply to you. When in doubt, call the DHMP Member Services department at 303-602-2100 or toll-free at 1-855-700-8140. This is the best source for information about your health care plan benefits.

Office Visits

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

Primary Care Visit:
In network: $25 per visit
Out-of-network: Not covered

Specialty Visit:
In network: $50 per visit
Out-of-network: Not covered

Allergy Testing and Treatment

Allergy specialist visits are covered with a referral from your provider.

In network: $50 copay
Out-of-network: Not covered

Allergy testing is covered

In network: $0 copay
Out-of-network: Not covered

Allergy injections given by a nurse when no other services are provided are not subject to cost sharing.

7. Benefits/Coverage (What is Covered)

Autism Services

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

- Evaluation and assessment services;
- Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. See Therapies for Habilitative and Rehabilitative benefit limits for cost sharing.

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

Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism service providers:

In network:
Birth through age 8: 550 visits/year
Age 9 to age 19: 185 visits/year
All visits are 25 minute session increments
Out-of-network: Not covered

Clinical Trials and Studies

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

- The member's in network primary care provider recommends participation, determining that participation has potential therapeutic benefit to the member;
- The clinical trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding clinical trials, as amended;
- The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
- Member has signed a statement of consent for participation in the clinical trial or study and understands all applicable copays, deductible and coinsurance will apply; and

Health care services excluded from coverage under the member's health plan will not be covered. DHMP will not cover any service, drug or device that is paid for by another entity involved in the clinical trial/study.

The member suffers from a condition that is disabling, progressive, or life-threatening.

- Extraneous expenses related to participation in the clinical trial or study or an item or service that is provided solely to satisfy a need for data collection or analysis are not covered.

See **Definitions** section for more information. Applicable cost sharing for type of service will apply.

Dietary and Nutritional Counseling

Coverage for health coach counseling is limited to the following covered situations:

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

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

Durable Medical Equipment, Prostethics and Orthotics

General

Durable medical equipment (DME) is covered if medically necessary and prior authorized by DHMP. This includes diabetic footwear. 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 primary care provider and request that the authorization be extended. All DME must be obtained from a DHMP network provider.

Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. The Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge. You will be billed for any additional items of DME, prosthetics, orthotics and/or necessary repairs and adjustments after the maximum benefit per year is paid by the Plan.

Deductible does not apply to Durable Medical Equipment.

In network: 20% copay of total cost
Out-of-network: Not covered
Benefit Maximum: $2,500 per member per calendar year

Dressings/Splints/Casting/Strapping

Dressings, splints, casts and strappings that are given to you by a provider are covered and no copayment is required. The cost of purchased dressings splints, casts and strappings apply to the DME benefit maximum.

In network: 20% coinsurance
Out-of-network: Not covered

Benefit Maximum: $2,500 per member per calendar year

7. Benefits/Coverage (What is Covered)

Prosthetic Devices

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

Coverage

Coverage includes the following prosthetic devices:

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

In network: 20% coinsurance
Out-of-network: Not covered
Does not accrue toward annual DME Maximum

No benefit maximum.

Prosthetic Devices Exclusions:

- Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate in newborn members, as described above.
- Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
- More than one prosthetic device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Replacement of lost prosthetic devices.
- Repairs, adjustments or replacements necessitated by misuse.

Orthotic Devices

Coverage

- Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.
- Not subject to deductible.

Orthotic Devices Exclusions:

- Corrective shoes and orthotic devices for podiatric use and arch supports.
- Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate for newborn members is covered when prescribed by a network provider.
- Experimental and research braces.
- More than one orthotic device for the same part of the body, except for replacements; spare devices or alternate use devices.
- Replacement of lost orthotic devices.
- Repairs, adjustments or replacements necessitated by misuse.

In network: Medically necessary orthotics are reimbursed up to $100 per calendar year
Out-of-network: Not covered

Diabetic Education and Supplies

If you have been diagnosed with diabetes by an appropriately licensed health care professional, you are eligible for outpatient self-management training and education, as well as coverage of your diabetic equipment and supplies, including formulary glucometers, test strips, insulin and syringes. These supplies are provided by your pharmacist with a prescription from your provider. Insulin pumps are covered through the DME benefit.

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

No copayments apply to early intervention services.

Benefit Maximum: 45 therapeutic visits 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."

7. Benefits/Coverage (What is Covered)

Emergency Services

Emergencies are life-threatening conditions or symptoms that arise suddenly and unexpectedly. These symptoms are so severe that you need medical attention now to prevent loss of life or limb. If you or a family member needs emergency care, go to the closest emergency room or dial 9-1-1. No authorization is required.

Services for the treatment of an emergency are covered. See definition of "Emergency" in the Definitions section. 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 primary care provider.

Follow-up care following an emergency department visit must be received from a DHMP network provider, unless you are traveling outside the network area cannot reasonably travel to the service area. In this case, one follow up visit outside the network is covered. If you are admitted to a non-network hospital as the result of an emergency and then subsequently transferred in network, you will only be responsible for the copayment for the first inpatient admission.

Ambulance Service

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

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

Urgent Care Services

Urgent care is immediate outpatient medical treatment for acute illness and injury. Urgent care services are covered at any urgent care center with the same cost sharing in and out of network. Members may also call the NurseLine at 303-739-1261 for assistance. In addition to the visit copayment, the applicable copayment and deductible/coinsurance applies when these services are don: CT, PET, MRI, MRA, Nuclear Medicine, Surgery.

In network: $75 copay
Out-of-network: $75 copay

Eye Examinations and Ophthalmology

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 per visit
Out-of-network: Not covered.

Family Planning Services

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

The following are covered if obtained from a network provider and applicable cost sharing applies:

- 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

Tubal ligations, vasectomies, and abortions up to the 15th week of pregnancy are covered. You must receive a referral from an in network provider, if the service is not provided by your primary care provider.

There are some limitations; please see exclusions section.

Infertility Services

In network: Not covered
Out-of-network: Not covered

Hearing Tests and Hearing Aids

Children age 18 and under are covered at 100%, no maximum benefit applies. Hearing tests and fittings for hearing aids are covered under clinic visits and the applicable copayment applies. Hearing aids do not apply to DME benefit maximum.

Adults (age 19 and over):
In network: 20% coinsurance with maximum benefit of $2,500 every 5 years Member responsible for amount over $2,500.
Out-of-network: Not covered

Children (18 and under):
In network: 100% covered
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 with prior authorization. The device is covered at 100%. Appropriate cost sharing will apply to surgical services associated with the device.

Home Health Care

Home health care provided by an DHMP network home health care provider is covered. Coverage requires periodic assessment by your primary care provider. A referral by your primary care provider and prior authorization by DHMP are required.

In network: 20% after deductible has been met.
Out-of-network: Not covered

Benefits Maximum: 60 visits per calendar year.

Newborn and Postpartum

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

Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy, as well as audiology services, in the home are covered when prescribed by your primary care provider or specialist and prior authorized by DHMP. Periodic assessment and continued authorization are required to extend 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 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. This includes home infusion therapy. Home nursing services are provided only when prescribed by your primary care provider 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 network hospice program. Each hospice benefit period has a duration of three months. Hospice Services must be prior authorized by DHMP before you receive your care.

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

In network: 20% after deductible has been met
Out-of-network: Not covered

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

Hospice Facility

Hospice may be provided as 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 DHMP. This includes care by the hospice staff, medical supplies and equipment, prescribed drugs and biologicals and family counseling ordinarily furnished by the hospice.

In network: 20% after deductible has been met.
Out-of-network: Not covered

Inpatient Hospital

Any admission to a hospital, other than an emergency admission, must be to an in network hospital and must be prior authorized by DHMP. Emergency hospitalization should be reported to DHMP at 303-602-2140 as soon as reasonably possible, preferably within 1 business day.

- Hospital services, including surgery, anesthesia, laboratory, pathology, radiology, radiation therapy, respiratory therapy, physical therapy, occupational therapy and speech therapy are covered. Oxygen, other gases, drugs, medications and biologicals (including blood and plasma) as prescribed are also covered. See "Limitations and Exclusions" section 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 per occurrence deductible of $150 and annual deductible have been met
Out-of-network: Not covered

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

Limitations: If you request a private room, the Plan 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.

7. Benefits/Coverage (What is Covered)

Immunizations

- There is no copay for covered 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 if they are provided at the Public Health Department at Denver Health. Prophylactic drugs for travel will be covered if prescribed by your primary care provider and if the drugs are on the Plan formulary. Some immunizations can be received in your primary care provider's office, so before visiting the Public Health Department at Denver Health, contact your primary care provider first for immunizations and prophylactic drugs.
- HPV vaccine is covered for eligible males and females 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 nurse, primary care provider, or specialist visit the required copayment will be requested.

Infusion Services

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

In network: 20% after deductible has been met
Out-of-network: Not covered

Injection Administration

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 primary care provider or specialist visit the required copayment will be requested.

In network: 20% after deductible has been met
Out-of-network: Not covered

Laboratory and Pathology Services

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

Certain genetic tests, such as testing to determine risk for developing cancer, are covered with prior authorization.

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 deductible has been 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 primary care provider or any network obstetrician. You do not need a referral from your primary care provider to see a participating OB/GYN, physician, Certified Nurse Midwife or Nurse Practitioner. Prenatal visits are treated as preventive well-woman visits.

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: $0 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 DHMP network. Only emergency deliveries are covered outside of DHMP network facilities. Any sickness or disease that is a complication of pregnancy or childbirth will be covered in the same manner and with the same limitations as any other sickness or disease.

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

In network: 20% after per occurrence deductible of $150 and annual deductible have been met
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.

Postpartum: Breastfeeding support and equipment is available at no cost to members with no cost sharing. Call 303-602-2100 for more information.

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 food to enter the small intestine or impairment of small bowel that impairs digestion and absorption of an oral diet is covered.

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 network facility.

Prior authorization is required for non-emergency admissions. Notification to the Plan should be made as soon as reasonably possible, preferably within one business day of an emergency admission.

In network: 20% after per occurrence deductible of $150 and annual deductible have been 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: 20% after per occurrence deductible of $150 and annual deductible have been met
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 DHMP network without a referral from your primary care provider.

In network: $50 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 DHMP network without a referral from your primary care provider.

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

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: 20% after per occurrence deductible of $150 and annual deductible have been met

Out-of-network: Not covered

Outpatient:
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

Note: Court ordered mental health services are covered. Applicable copays/coinsurance apply.

Newborn Care

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

The Plan 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 DHMP network providers and must be prior authorized by the Utilization 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 designed 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 stay
Out-of-network: $300 copay per stay

Ostomy Supplies

Colostomy, ileostomy and urostomy supplies are covered.

In network: 20% coinsurance
Out-of-network: Not covered

Oxygen/Oxygen Equipment

Equipment for the administration of oxygen is covered. Oxygen is covered, and no cost sharing is required. There is no benefit maximum.

In network: 100% covered; equipment: 20% coinsurance
Out-of-network: Not covered

Pharmacy Benefits

DHMP provides a pharmacy benefit that covers medically necessary drugs as required by the requirements and guidelines discussed below. Depending upon where you have your prescription filled, copays and restrictions may vary. Prescription copay information for your plan is listed in the Pharmacy Benefits chart.

Where You Can Fill Your Prescription

- DHMP offers thousands of pharmacies nationwide for you to fill your prescriptions. These pharmacies include any Denver Health Pharmacy, Albertsons, King Soopers, Rite-Aid, Safeway, Target, Walgreens, and more.
- DHMP has conveniently located Denver Health Pharmacies in many of the Denver Health clinics. While you have the choice to fill your prescription at any network pharmacy, filling your prescriptions at Denver Health Pharmacies will give you the lowest copay and allows your provider to see your prescription fill information. This helps your provider to give you the most complete care at each visit.

Remember, to fill a prescription at a Denver Health Pharmacy your prescription must be written by a Denver Health provider.

Denver Health Refill Request Line
1-888-436-3442

Denver Health Pharmacy by Mail
(requires credit card registration/order form)
Monday-Friday, 9am-5pm
303-602-2326

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

Gipson Eastside Pharmacy 303-436-4600, #7
501 28th Street

Infectious Disease (ID) Pharmacy 303-602-8762
605 Bannock Street

La Casa/Quigg Pharmacy 303-602-6700
4545 Navajo Street

Montbello Pharmacy 303-602-4025
12600 Albrook Drive

Sandos Westside Pharmacy 303-436-4200
1100 Federal Blvd

To find a pharmacy near you visit www.denverhealthmedicalplan.org or call Member Services.

Refilling Your Prescription

- It is best to call to refill your prescription 3-5 working days before you need your refill. Your prescription may be refilled once 75% has been used. This is calculated using the original prescription directions. If the directions have changed please contact your pharmacy or provider for an updated prescription. If your prescription directions have changed or you need an early refill, please let the pharmacy know ahead of time. The pharmacy will need extra time to talk to your provider to get a new prescription or get authorization to fill your prescription early.
- When you use Denver Health Pharmacies you may order your prescriptions by calling the Denver Health Refill Request Line (which is also the number on your prescription bottle), or by visiting www.denverhealthmedicalplan.org.

Mail Order Pharmacy - Denver Health Pharmacy by Mail

- You can save time and money by signing up to have your prescriptions delivered to your home by mail. Ask your provider to write your prescriptions for a 90 day supply so you can get your prescriptions by mail. A registration/order form is required to sign up and you must keep a credit card on file to pay for your medications.
  - » Registration/order forms are available at www.denverhealthmedicalplan.org, at any of the Denver Health pharmacies, or by calling the Denver Health Pharmacy by Mail at 303-602-2326 or toll-free at 1-866-347-3345.
- Medications are sent through the U.S. Postal Service within the state of Colorado. Medications that need refrigeration can be mailed. However controlled substances cannot be filled by Denver Health Pharmacy by Mail.

90-Day Supply at Retail

- Your pharmacy benefit allows you to get a 90 day supply of medication at any Choice 90 participating retail pharmacy. To find out if your drug and/or pharmacy are eligible for this benefit visit www.denverhealthmedicalplan.org and click the "Drug Formulary Search" link for your plan or call Member Services.

7. Benefits/Coverage (What is Covered)

Your Formulary

- The DHMP formulary is a list of covered drugs that shows the copayment tier and prior authorization requirements for each medication. We have selected the tiers and determined the criteria for prior authorization based on efficacy and cost-effectiveness. There is a different copayment for each tier. The formulary helps providers choose the most appropriate and cost-effective drug for you.
  - » Your formulary covers many drugs including oral anti-cancer drugs.
- Some drugs require a prior authorization from the Plan. These drugs are noted on the formulary as "PA". Clinical information on why the PA drug is needed is required on the prior authorization request. DHMP will review the prior authorization request according to our criteria for medical necessity and determine if the drug will be covered.
- If your provider writes a prescription for a drug that is not on the formulary, there may be a covered drug that works just as well for you. If your provider does not want to change the drug to a formulary alternative, you will need a prior authorization from the Plan.

Please visit www.denverhealthmedicalplan.org where you will find:

- A list of pharmaceuticals, including restrictions and preferences
- Information on how to use the pharmaceutical management procedures
- An explanation on limits or quote
- Information on how practitioners must provide information to support an exception request
- The process for generic substitution, therapeutic interchange and step-therapy protocols

You may also call and request a printed copy of this information by calling Member Services.

Generic and Brand Name Drugs

- You can save money by using generic drugs which have lower copays. Generic drugs are approved by the U.S. Food and Drug Administration for safety and effectiveness and are made using the same strict standards that apply to the brand name alternative. By law, generic drugs must contain identical amounts of the same active drug ingredient as the brand name drug.
- A generic preferred program is in place. This means if you fill a prescription with a brand name drug when a generic is available, you will have to pay the copay plus the difference in cost between the generic and the brand name drug. If your provider feels you need the brand name drug, they can fill out a prior authorization request form to tell DHMP why the brand is needed. If approved you will only need to pay the brand copay.

Drug Exclusions (See General exclusions and limitations for additional limitations)

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

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

	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**

7. Benefits/Coverage (What is Covered)

Preventive Care

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 web site at: www.denverhealthmedicalplan.org. Preventive care services are designed to keep you healthy or to prevent illness, and are not intended to treat an existing illness, injury or condition. Please refer to the following chart for your cost-sharing that may apply to preventive care services received by a network provider. Please keep in mind the following:

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

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: • Prenatal visits • Medical history • Physical exam of pelvic organs including PAP test • Vaginal smear • Physical exam of the breasts • Rectal exam including FOBT • Consultation for birth control, if requested • Urinalysis	$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

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

Radiology/X-Ray Diagnostic and Therapeutic Services

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

In network: 20% after deductible has been met
Out-of-network: Not covered

Radiation Therapy:
In network: 20% after deductible has been met
Out-of-network: Not covered

MRI and PET Scans:
In network: $150 copay
Out-of-network: Not covered

Renal Dialysis

Renal dialysis is covered if provided at an authorized facility.

In network: 20% after deductible has been met
Out-of-network: Not covered

7. Benefits/Coverage (What is Covered)

Skilled Nursing Facility/Extended Care Services

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

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

Benefit Maximum: 100 days per calendar year

Sleep Studies

Covered if provided at a network facility or in home.

In network: 20% after deductible has been met
Out-of-network: Not covered

Smoking Cessation

Talk to your primary care provider 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, if approved. You also have access to a Health Coach who can assist and support you through the process. For more information, contact Member Services at 303-602-2100.

Substance Abuse Services

Referral by your primary care provider and prior authorization by DHMP 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 one business day.

In network: 20% after deductible has been met
Out-of-network: Not covered

Inpatient Substance Abuse Rehabilitation Services

Your admission and treatment must be in a network facility and prior authorized by the Utilization Management Department.

In network: 20% after annual deductible and per occurrence deductible of $150 are both met.
Out-of-network: Not covered

Exclusions: Maintenance, residential care or aftercare following a rehabilitation program

Outpatient Substance Abuse 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 DHMP network.

In network: $50 copay
Out-of-network: Not covered

Note: Court ordered mental health services are covered. Applicable copays/coinsurance apply.

Surgery Services

Inpatient Surgery

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

In network: 20% after annual deductible and per occurrence deductible of $150 are both met
Out-of-network: Not covered

Outpatient Surgery

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

In network: 20% after annual deductible and per occurrence deductible of $75 are both met
Out-of-network: Not covered

7. Benefits/Coverage (What is Covered)

Oral/Dental Surgery

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

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

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

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

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

Breast Surgery

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

Reconstructive Surgery

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

Transplants

Corneal, kidney, kidney-pancreas, heart, lung, heart-lung, and liver transplants 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 Utilization Management Department.

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

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

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

Out-of-network: Not covered

Benefit Maximum: Two transplant procedures, regardless of whether the same or a different organ, per member per lifetime.

7. Benefits/Coverage (What is Covered)

Therapies

Habilitative Services

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

In network: $25 copay per visit
Out-of-network: Not covered

Prior Authorization Required.

Benefit Maximum: 20 visits per calendar year for each of physical therapy, occupational therapy and speech therapy to learn skills for the first time or maintain current skills

Rehabilitative Services

- Physical therapy, occupational therapy and speech therapy will be authorized only until maximum medical improvement is reached or the annual benefit is exhausted, whichever comes first. However, early intervention services for children up to age 3 with developmental delays are covered without regard to maximum medical improvement. See "Early Intervention Services."

  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.

- **Cardiac Rehabilitation:** Treatment in a cardiac rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

  In network: $25 copay per visit
  Out-of-network: Not covered

- **Pulmonary Rehabilitation:** Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities.

  In network: $25 copay per visit
  Out-of-network: Not covered

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

Non-network providers

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

- Provided under prior written referral by a participating primary care provider and prior authorized by the Utilization Management department or
- Provided in an Emergency or urgent circumstance, and notification is made to the Utilization Management department as soon as reasonably possible, preferably within 1 business day.

General Exclusions

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

- **Adaptive Equipment/Corrective Appliances:** Adaptation to telephone for the deaf; replacement of artificial eyes if lost, stolen or damaged; reading aids, vision enhancement devices; cochlear implants for ages 18 and over; wheelchair ramps; home remodeling or installation of bathroom equipment; prosthetic devices (except for artificial limbs and breast prostheses).
- **Ambulance Services:** Ambulance service for non-emergency care or transportation except as requested by DHMP.
- **Artificial Hair:** Wigs, artificial hairpieces, hair transplants or implants, even if there is a medical reason for hair loss.
- **Care Not Medically Necessary:** Medical care, procedures, equipment, supplies, and/or pharmaceuticals that are not consistent with generally accepted principles of professional medical practice, as determined by whether or not: (1) the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual; (2) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; (3) services and interventions, not in widespread use, are based on scientific evidence.
- **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 18 and under-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 (primary care provider) as medically necessary as a result of trauma.
- **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 DHMP. 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:** Some drugs are not covered at all. These include drugs for the following: cosmetic use (anti-wrinkle, hair removal, and hair growth products), dietary supplements, blood or blood plasma (anti-hemophilic factor VIII and IX are covered), infertility, over-the-counter drugs (unless listed in the formulary), pigmenting/de-pigmenting, therapeutic devices or appliances (unless listed in the formulary), prescription vitamins (unless listed in the formulary), investigational or experimental treatments.

8. Limitations and Exclusions (What is Not Covered and Pre-Existing Conditions)

- **Experimental Procedures and Drugs:** Medical care, procedures, equipment, supplies, and/or pharmaceuticals determined by DHMP to be experimental, investigational, or not generally accepted in the medical community are not covered. This means any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are considered to be unsafe, experimental, or investigational. This is determined by formal or informal studies, opinions and references to or by the American Medical Association, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies, experts in the field, and any other association or federal program or agency that has the authority to approve medical testing, treatment, or pharmaceutical drug efficacy and appropriateness.
- **Extended Care:** Sanitarium, custodial or respite care (except as provided under Hospice Services), maintenance care, chronic care and private duty nursing.
- **Eyewear:** Glasses, contacts, all eyewear except as noted in specific plan benefits.
- **Family Planning and Infertility:** Reversal of voluntarily induced infertility (sterilization); 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.).
- **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.
- **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.
- **Medical Food:** Food products for cystic fibrosis or lactose or soy intolerance or other food allergies.
- **Neurostimulators:** Replacements or repairs, including batteries.
- **Obesity:** Commercial weight loss programs or exercise programs, , are not covered benefits although discount programs may be available.
- **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) are not covered. This includes vitamins, minerals or special diets, even if prescribed by a physician (except medical food for children with inherited enzymatic disorders) with the exception of formulary prescription items such as electrolytes, certain vitamins and minerals listed in the Denver Health Medical Plan formulary.
- **Paternity Testing**
- **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.
- **Refractive Surgery:** Vision correction surgery such as Lasik. Except as noted in specific plan benefits.
- **Residential Treatment:** Residential treatment facilities that provide 24-hour care with counseling, therapy and trained staff. Long term, non-structured residential treatment.
- **Transplants:** Organ transplants not listed in Overview of Covered Services; donor-related expenses for DHMP members who are donating to an individual who is not a DHMP member.

8. Limitations and Exclusions (What is Not Covered and Pre-Existing Conditions)

- **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

About Your Medical Benefits

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

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 table at the beginning of this handbook. You are responsible for all expenses incurred for non-covered services.

Benefit Maximums

Benefit maximums are the limits set by DHMP on the number of visits per calendar year or services per lifetime.

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.

Out-of-Pocket Maximum

This is the maximum amount you pay every year. Deductibles, coinsurance and copays apply to the out-of-pocket maximum.

10. Claims Procedure (How to File a Claim)

How to File a Claim

For Medical Service

When you receive health care services, you must show your provider your identification card. Your identification card gives your provider important information about your benefits, 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, coinsurance or deductible, if applicable, and should pay them directly to your provider.

There are situations in which you may need to file a claim for care you receive. If you receive emergency or urgent care from a provider outside of the DHMP network, you may be asked to pay the entire bill or a portion of the bill at the time of service. You may be required to pay the entire amount to the provider at the time of service. DHMP will reimburse you up to the limits noted in 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
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992

To be reimbursed for pediatric hearing aids, or 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 eligible up to the benefit maximum. Claims submitted later than 120 days after the date of service may be denied due to late filing.

Authorized claims that were part of a utilization management review, will be paid within 30 days of receipt.

For Pharmacy Service

Present your DHMP identification card at any network pharmacy when you have your prescriptions filled. You are responsible for paying the pharmacy copayment. If you are out of the network area and cannot locate a network pharmacy, please call the Member Services Department at 303-602-2100 or toll-free at 1-855-700-8140 for information on how to get your prescription filled. If you pay the full cost for an eligible prescription medication, you have 180 days to mail your pharmacy receipt, along with your name, mailing address and member ID number, to the following address:

Pharmacy Department
DHMP
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. Claims Procedure (How to File a Claim)

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 toll-free at 1-855-700-8140, 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 toll-free at 1-855-700-8140. You may also write to:

DHMP
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 Appeals and Complaints (Grievances) section.

Claims Timeframes

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

Claims Fraud

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or payment from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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.

When Another Party Causes Your Injuries or Illness

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

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

- You will owe DHMP any money that the Plan is unable to collect because of your, or your lawyer's, lack of help or interference. You agree to pay to DHMP any attorney's fees and costs that the Plan must pay in order to collect this money from you. 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.
- 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.

Disclosure of Health and Billing Information to Third-Parties

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

Venue

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

11. General Policy Provisions

Privacy/HIPAA Information

Confidential Information

DHMP is committed to protecting your privacy. All patient information is kept confidential. In addition, we will not discuss any of your Protected Health Information (PHI) with anyone other than yourself without approval. If you'd like for us to discuss your information with another family member, you will need to fill out the Designation of Personal Representative (DPR) form (see Attachment B in your handbook). Your handbook can be accessed on our web site at www.denverhealthmedicalplan.org, or you may call Member Services at 303-602-2100 and request a hard copy be mailed to you.

Also, complete privacy information is available on our web site at www.denverhealthmedicalplan.org, or you may call Member Services and request it be mailed to you.

Original Effective Date: April 14, 2003
Revised Effective Date: September 23, 2013

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

PLEASE REVIEW IT CAREFULLY.

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

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

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

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

Our Uses and Disclosures:

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

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

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

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

State and Federal Laws Pertaining to Personal Health Information

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

- If you are injured or unconscious, we may share PHI with your family or friends to ensure you get the care you need and talk about how the care will be paid for.
- To a personal representative designated by you or by law.

- To state and federal agencies that regulate us, such as the US Department of Health and Human Services, Colorado Division of Insurance, Colorado Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing.
- For public health activities. This may include reporting disease outbreaks or helping with product recalls.
- To public health agencies if we believe there is a serious health or safety threat.
- With a health oversight agency for certain oversight activities, such as: audits, inspections, licensure, and disciplinary actions.
- To a court or administrative agency, for example, pursuant to a court order or search warrant.
- For law enforcement purposes or with a law enforcement official.
- To a government authority regarding child abuse, neglect, or domestic violence.
- To respond to organ and tissue donation requests and work with a funeral director or medical examiner.
- For special government functions, such as for national safety.
- For job-related injuries because of state worker compensation laws.

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

Other uses and Disclosures of Health Information:

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

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

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

Your Rights Regarding Personal Health Information

The following are **your rights** with respect to your health information. If you would like to exercise the following rights, please contact the Privacy Officer by telephone at (303) 602-2004, facsimile at (303) 602-2074, and via email at privacyofficerdhmp@dhha.org, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m., or by US mail at or walk-in at Denver Health Medical Plan, Inc. Attn: Privacy Officer at 938 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 our Privacy Officer, and must state the specific restriction requested and to whom that restriction would apply

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

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

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

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

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

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

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

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

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

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

- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. We are **not** required to provide you with an accounting of the following:
  1. Any information collected prior to April 14, 2003;
  2. Information disclosed or used for treatment, payment, and health care operations purposes;
  3. Information disclosed to you or pursuant to your authorization;
  4. Information that is incident to a use or disclosure otherwise permitted;
  5. Information disclosed for a facility's directory or to persons involved in your care or other notification purposes;
  6. Information disclosed for national security or intelligence purposes;
  7. Information disclosed to correctional institutions, law enforcement officials, or health oversight agencies;
  8. 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 Privacy Officer. We will act on your request for an accounting within 60 days. We may need additional time to act on your request. If so, we may take up to an additional 30 days. Your first accounting will be free. We will continue to provide you with one free accounting upon request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. We will inform you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

Please be advised that oral, written, and electronic PHI is protected internally. In the case of a breach, we have a duty to notify affected individuals of a breach of PHI

- ***You have a right to receive a copy of this notice upon request at any time***. Requests for a copy of this notice should be directed to the Privacy Officer.

Questions or Complaints

If you have any questions about this notice, how we use or share information, or if you believe your privacy rights have been violated, please contact the Privacy Officer at (303) 602-2004, facsimile at (303) 602-2074, or via email at privacyofficerdhmp@dhha.org, Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. You may also contact us by US mail at Denver Health Medical Plan, Inc. Attn: Privacy Officer at 938 Bannock Street, Mail Code 6000, Denver, CO 80204.

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

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

Member Rights and Responsibilities

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

Member's Rights

- Have access to practitioners and staff who are committed to providing quality health care to all members without regard for religion, race, national origin, handicap, sex or sexual orientation, or age.
- Receive medical/behavioral health care that is based on objective scientific evidence and human relationships. A partnership based on trust, respect, and cooperation among the provider, the staff and the member will result in better health care.
- 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, disability, or participation in a publicly financed program.
- To choose or change your primary care provider within the network of providers, to contact your primary care provider whenever a health problem is of concern to you and arrange for a second opinion if desired.
- 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.
- Get copies of your medical records or limit access to these records, according to state and federal law;
- Ask for a second opinion, at no cost to you;
- To know the names and titles of the doctors, nurses, and other persons who provide care or services for the member.
- A candid discussion with your provider about appropriate or medically necessary treatment options for your condition regardless of cost or benefit coverage.
- A right to participate with providers in making decisions about your health care.
- To request or refuse treatment to the extent of the law and to know what the outcomes may be.
- 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 DHMP network. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered service.
- To learn more about your primary care provider and his/her qualifications, such as medical school attended or residency, go to www.denverhealthmedicalplan.org and click on Find a Doctor/Provider for our web based provider directory or call Member Services at 303-602-2100.
- 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, abuse or change in eligibility status at the time of service.
- To receive a standing referral, from a primary care provider 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.
- To voice a complaint about or appeal a decision concerning the DHMP organization or the care provided and receive a reply according to the grievance/appeal process.

11. General Policy Provisions

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 DHMP network without getting a referral from your primary care provider.
- To see your current non-network provider for prenatal care, until after delivery of the baby if you become a member of DHMP during your second or third trimester. This is dependent upon the non-network provider agreeing to accept DHMP's arrangements.

To continue to see your non-network doctor(s) or provider(s), when medically necessary, for up to 60 days after becoming a DHMP member. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

- For DME, DHMP will authorize up to 75 days from a non-network DME provider. (Dependent upon the non-network provider accepting DHMP's arrangements for this transition.)

Member's Responsibilities:

- To treat providers and their staff with courtesy, dignity and respect.
- To pay all premiums and applicable cost sharing (i.e. deductible, coinsurance, copays).
- To make and keep appointments, to be on time, call if you will be late or must cancel an appointment, and to have your DHMP identification card available at the time of service and pay for any charges for non-covered benefits.
- To report your symptoms and problems to your primary care provider and to ask questions, and take part in your health care.
- To learn about any procedure or treatment and to think about it before it is done.
- To think about the outcomes of refusing treatment that your primary care provider suggests.
- To get a referral from your primary care provider 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 Member Services representative with any questions.
- Inform providers or a representative from DHMP when not pleased with care or service.

DHMP Records

You have the right to examine, without charge, DHMP's administrative office or other specified locations, and certain documents of the Plan, such as detailed annual reports and plan descriptions. You may obtain copies upon written request to the DHMP Director of 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 members in accordance with all applicable State and Federal laws, including HIPAA. In accordance with HIPAA, DHMP may use any and all of a member's medical, billing and related information for the purposes of utilization review, care management, quality review, processing of claims, processing of appeals, payment, collection and subrogation activities, financial audit and coordination of benefits, to the extent permitted by HIPAA. Members authorize DHMP's use of this type of information for health plan operations when they sign the enrollment form or approve it online. Outside of these activities, DHMP will not release any information that would directly or indirectly indicate a member is receiving or has received Covered Services, unless authorized to do so by the member or HIPAA. DHMP will advise its employees, agents, and subcontractors, if any, that they are subject to these confidentiality requirements.

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

To make a request, call Member Services at 303-602-2100 or toll-free at 1-855-700-8140. Members also have the right to inspect and obtain copies of their medical records maintained by DHMP network providers. Please contact the individual provider for more details.

11. General Policy Provisions

Notice of Privacy Practices

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

The DHMP Notice of Privacy Practices is available on the DHMP web site at www.denverhealthmedicalplan.org. A new notice will be provided if there is any material change in our practices. You may, at any time, obtain a copy of the notice by contacting Member Services at 303-602-2100 or by calling toll-free at 1-855-700-8140.

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 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 DHMP network unless otherwise directed by your primary care provider and authorized by DHMP.

Affirmative Statement about Incentives

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

DHMP affirms the following regarding utilization management (UM) practices:

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

Please feel free to contact DHMP at 303-602-2100 should you have questions regarding this practice.

Relationship between DHMP and network providers

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

Statement of Appropriate Care

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

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

If you feel that a DHMP representative or network provider has violated any of the above principles, you can contact the Member Services department at 303-602-2100 or toll-free at 1-855-700-8140.

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.

Quality Improvement Program

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

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

Please visit www.denverhealthmedicalplan.org or call Member Services to learn more about our Quality Improvement Program such as program goals, processes, outcomes and specific measurements.

12. Termination/Nonrenewal/Continuation

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.

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.

13. Appeals and Complaints

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 expression of dissatisfaction about the quality of care you receive, the failure of a provider or the Plan to accommodate your needs, an unpleasant experience or any other service issue, including health plan benefit payment decisions.

An Appeal is a written or oral request that the Plan review an adverse decision about a requested medical service, care or treatment, or benefit payment decisions. An adverse decision is defined as a denial of a preauthorization for a covered benefit; a denial of benefits based on the grounds that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care; a rescission or cancellation of coverage that is not attributable to failure to pay premiums and that is applied retroactively; a denial of benefits on the grounds that the treatment or service is experimental or investigational; or a denial of coverage based on initial eligibility determination. There are two types of an Appeal: (1) a pre-service appeal and (2) a post-service appeal. A pre-service appeal is defined as a request to change an adverse determination for care or service that the organization must approve, in advance of the member obtaining care or services. A post-service appeal is defined as a request to change an adverse determination for care or services that has already been received by the member.

Who Can File an Appeal

An appeal can be requested by you (the member), a person that you designate, such as a relative, friend, advocate, ombudsman, an attorney, or any physician, to act on your behalf as your appointed representative. To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a Designation of Personal Representative Form. You may obtain a copy of the Designation of Personal Representative Form at the end of this Member Handbook or call the Member Services Department at (303) 602-2100 to learn how to name your appointed representative. Upon receipt of the completed Designation of Personal Representative Form, we will process the appeal.

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 (303) 602-2100 or toll-free at 1-855-700-8140, TTY/TDD users should call 303-602-2129. You may also file a grievance by completing the Member Complaint and Appeal Form that is located at the end of this Member Handbook or via our web site at www.denverhealthmedicalplan.org. You may mail or fax your Grievance to the following address:

DHMP
ATTN: Grievance and Appeal Department
777 Bannock St., MC 6000
Denver, CO 80204-4507
Fax: (303) 602-2078

The Grievance team will conduct an investigation of your grievance. You will receive a written letter providing a resolution to your grievance within 30 calendar days.

How to File an Appeal

If you have received a letter stating that the requested service, care or treatment was denied, the decision is called an adverse determination and is subject to the appeal process. Before an appeal is filed, your physician may hold a peer-to-peer conversation with the Medical Director who rendered the adverse determination.

Peer-to-Peer Conversation

Your physician has the opportunity to hold a peer-to-peer conversation with the Medical Director regarding an adverse determination. Your physician must call the Utilization Management department at 303-602-2140 to initiate the peer-to peer conversation. The conversation must occur within five calendar days of the request for a peer-to-peer conversation.

Timeframes for Appeals

There are two types of appeals: (1) a pre-service appeal, or (2) a post-service appeal. Additionally, there are two levels of internal appeals: (1) a first level appeal and (2) a voluntary second level of appeal. The 1st level Appeal request must be received within 180 calendar days after the date you received notice of the initial denial.

First Level Appeal Reviews

First level pre-service appeal reviews must be evaluated by a physician reviewer with the clinical expertise in the same or similar specialty to evaluate the requested service. The physician reviewer will not have been involved in any prior decision of the matter nor will be a subordinate of any previous decision makers or have a financial interest in the appeal or outcome of the review. For first level post-service appeal requests, a physician reviewer is not required to evaluate the request.

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 20 calendar days following receipt of your request for an appeal review. The notice letter will include 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 Member Handbook provision, guideline, criteria or other documents relied upon in making the decision.

13. Appeals and Complaints

The notice will also describe the way in which to obtain a copy of any applicable guideline or criteria used and give you information about your option for a voluntary second level review.

Voluntary Second Level Appeal Reviews

If you do not agree with the outcome of the first level appeal decision, you may request another review, in writing, called a "voluntary second-level appeal" within thirty (30) days of the first level adverse determination. You may file the voluntary second level appeal request by completing the Member Complaint and Appeal Form that is located at the end of this Member Handbook or by obtaining the Form via our web site at www.denverhealthmedicalplan.org.

An Appeals Committee will conduct a second level review. All committee members will not have been involved in any prior decision of your issue nor be subordinates of previous decision makers. You have the right to participate in the second level review in person or by telephone conference but are not required to. You will be notified, in writing, of the Appeals Committee's decision within ten (10) days.

You may request a copy of the materials we intend to present at the review. You must submit your request at least five days before the Committee review meeting. We 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.

All comments, documents, records and other information about the request will be considered. Our response 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

You have the option of an independent external review by qualified experts upon the denial of a request for coverage. In order to request an independent external review, you must have pursued at least one level of the internal appeal process or have pursued an expedited review of a denial of a benefit. You must file the request for an external review within four (4) months of receipt of the first level review decision or within sixty (60) calendar days of receipt of the second level review decision. You may also request an expedited external review. Upon timely receipt of your request for an independent external review, DHMP will send you a letter describing the certified independent review entity that the Division of Insurance has selected to conduct the review. Please contact the Grievance and Appeal Department at (303) 602-2261 to have the consent form sent to you.

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 45 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 the 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 three working days of notification, if the initial notification was by telephone. Expedited Appeal review requests can be made orally at 303-602-2261, or in writing at:

DHMP
ATTN: Grievance and Appeal Department
777 Bannock St., MC 6000
Denver, CO 80204-4507
Fax: (303) 602-2078

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

14. Information on Policy and Rate Changes

All commercial insurance policies offered by DHMP 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.

Amendment or Termination of this Plan

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

15. Definitions

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

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

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

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

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

A. FEDERALLY FUNDED TRIALS- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   i. The National Institutes of Health.
   ii. The Centers for Disease Control and Prevention.
   iii. The Agency for Health Care Research and Quality.
   iv. The Centers for Medicare & Medicaid Services.
   v. cooperative group or center of any of the entities described in clauses (i)through (iv) or the Department of Defense or the Department of Veterans Affairs.
   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
   vii. Any of the following if the conditions described in paragraph (2) are met:
      a. The Department of Veterans Affairs.
      b. The Department of Defense.
      c. The Department of Energy.

B. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

C. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

A. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and

B. assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

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

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

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

15. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

15. Definitions

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

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

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

Hospice Care: An alternative way of caring for terminally ill individuals that stresses palliative care as opposed to curative or restorative care. Hospice care focuses upon the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the patient. Hospice care is not limited to medical intervention, but addresses physical, social, psychological and spiritual needs of the patient. Hospice services include but are not necessarily limited to the following: nursing, physician, certified nurse aide, nursing services delegated to other assistants, homemaker, physical therapy, pastoral, counseling, trained volunteer and social services. The emphasis of the hospice program is keeping the hospice patient at home among family and friends as much as possible.

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

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

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

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

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

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

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

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

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

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

Observation Stay: A hospitalization lasting 23 hours or less.

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

Out-of-Pocket Maximum: The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy.

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

15. Definitions

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

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

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

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

Prior Authorization: If approved, provides an assurance by the Plan to pay for a medically necessary covered benefit provided by a designated provider for an eligible Plan member and is received prior to receiving a specific service, treatment or care. This process can be initiated by a provider, patient, or designated patient representative.

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.

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

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

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

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, and
6. 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 primary care provider to a network specialist or specialty treatment center in the DHMP network for illness or injury that requires ongoing care.

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

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

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.

15. Definitions

US Preventive Task Force (USPSTF) 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.

US Preventive Task Force (USPSTF) 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.

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.

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

ATTACHMENT A

Member Complaint and Appeal Form

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

Denver Health Medical Plan
Attn: Grievance and Appeal Department
938 Bannock St., Mail Code 6000
Denver, CO 80204-0606
Phone: 303-602-2261
Fax: 303-602-2078
www.denverhealthmedicalplan.org

DHMP Plan Type - Please check one:

- **DHA Medical Care (Plan A)** ☐
- **DHA Point of Service (POS)** ☐
- **HMO Expanded** ☐
- **CSA/DERP: HMO** ☐ ***or*** **DHMO** ☐
- **DPPA: HMO** ☐ ***or*** **DHMO** ☐
- **Elevate Silver: Basic** ☐ ***or*** **Expanded** ☐
- **Elevate Gold: Basic** ☐ ***or*** **Expanded** ☐

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

Last Name:	First Name:
Address:	City/State/Zip:
Telephone #:	Member ID#:
Date of Birth:	Medical Record #:

If other than Member listed above, please provide the following information for the person submitting the complaint or appeal. You must include a completed Designation of Personal Representative (DPR) Form with your request. Without this form, we will be unable to process your complaint or appeal. The DPR Form can be obtained by visiting our Web site or calling the telephone number provided above.

Name:	Telephone #:
Relationship to Member: Spouse ☐ Son/Daughter ☐ Parent/Legal Guardian ☐ Member's Provider ☐ Other ☐ (please specify) _____	
Mailing Address:	City/State/Zip:

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

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

Is this in regards to a denied claim? Yes ☐ No ☐ If Yes: Claim # _____ Date(s) of Service:_____ Provider Name:_____	Is this in regards to a denied medical service or treatment? Yes ☐ No ☐ If Yes, Please provide the date of the denial letter: _____

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

Member Signature:	Date:
Designated Personal Representative Signature:	Date:

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

Internal Use Only – Please do not write below this line

Receipt Date:_____ Complaint ☐ (or) Appeal ☐ Received By:_____

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

ATTACHMENT B

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, MC#6000
Denver, CO 80204
Phone: 303-602-2261 • Fax: 303-602-2094

ATTACHMENT C
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 D
Denver Health Medical Plan, Inc.

2014 DHMO
Member Reimbursement Form

Member's Name:_____

Mailing Address: _____

Member's I.D. Number:_____

ORTHOTICS:

_____ L3000 $100.00

Maximum benefit per calendar year

HEARING AID:

_____ V5100

$2500.00 every 5 years, if 18 years of age or older
Under age 18, covered at 100%

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

Mail Claims to: Denver Health Medical Plan
Attn: Claims Department
P.O. Box 24992
Seattle, WA 98124-0992

16. Index

16. Index

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

YOU HAVE THE RIGHT TO DESIGNATE ANY PRIMARY CARE PROVIDER WHO PARTICIPATES IN OUR NETWORK AND WHO IS AVAILABLE TO ACCEPT YOU OR YOUR FAMILY MEMBERS. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Denver Health Medical Plan, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services at 303-602-2100 or visit our web site at www.denverhealthmedicalplan.org. The lifetime limit on the dollar value of benefits under Denver Health Medical Plan, Inc. no longer applies. Dependents may be covered up to the age of 26.

All DHMP 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.org

Form No. CSA_DERP 2014 DHMO
Created on 11/26/13

EXHIBIT 2

To agreement with
Denver Health Medical Plan, Inc.

PERFORMANCE GUARANTEES

EXHIBIT 2
To Denver Health Medical Plan, Inc. Service Agreement

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.

CAH
PS:

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

ACORD

CERTIFICATE OF LIABILITY INSURANCE

OP ID: RL

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 A 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

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 11/25/2014

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
Arthur J. Gallagher Risk Management Services Inc.
6399 S Fiddler's Green Cir #200
Greenwood Village CO 80111-4949

CONTACT NAME: Robin Layman
PHONE (A/C, No, Ext): 303-889-2628 FAX (A/C, No):
E-MAIL ADDRESS:

INSURED
DENVHEA-01
Denver Health & Hospital Authority Denver Health Medical Plan, Inc.
660 Bannock Street, 5th Floor
Denver, CO 80204-4507

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A	Lexington Insurance Company	19437
INSURER B	Safety National Casualty Corporation	15105
INSURER C	Atlanatic Specialty Insurance Company	20443
INSURER D	Lloyd's Syndicate 2623/623 Beazley	
INSURER E		
INSURER F		

COVERAGES **CERTIFICATE NUMBER:** 1645136895 **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			6795055	1/1/2014	1/1/2015	EACH OCCURRENCE	$1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$50,000
	CLAIMS MADE X OCCUR						MED EXP (Any one person)	$5,000
	X Prof Lia Clms md						PERSONAL & ADV INJURY	$1,000,000
	X RetroDt 01/01/97						GENERAL AGGREGATE	$3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$1,000,000
	X POLICY PRO-JECT LOC						Retention	$250,000
A	AUTOMOBILE LIABILITY			047082778	1/1/2014	1/1/2015	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	X ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$
	HIRED AUTOS X NON-OWNED AUTOS						Retention	$150,000
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS MADE						AGGREGATE	$
	DED RETENTION $							$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			SP4049975	1/1/2014	1/1/2015	X WC STATU-TORY LIMITS OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N N/A						E.L. EACH ACCIDENT	$1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$1,000,000
							E.L. DISEASE - POLICY LIMIT	$1,000,000
C	Managed Care Liability			MCR-6862-14	1/1/2014	1/1/2015	Each Claim Limit	$5,000,000
							Aggregate Limit	$5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

The above Workers Compensation policy includes $600,000 Self Insured Retention.
Insurer D Privacy/Cyber Liability Insurance Policy Aggregate Limit of Liability $3,000,000
With respects contract number CB12-0673
The City and County of Denver, its elected and appointed officials, employees and volunteers are included as Additional Insureds for General Liability pursuant to and subject to the policy's terms, definitions, conditions and exclusions

CERTIFICATE HOLDER

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

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