

Quick Reference Guide

WE TAKE YOUR
HEALTH
personally.

Point of Service
Denver Health Authority (DHA)



2012



Table of Contents

In this guide you will find information to help you use your Denver Health Medical Plan, Inc. (DHMP) benefits. For detailed information, please refer to the member handbook that you can view online at www.denverhealthmedicalplan.com, or by contacting Member Services at 303-602-2100.

How DHMP Works 3
 Welcome to DHMP..... 3
 Your Health Network..... 3
 Family Health Centers 4
 Hospitals 4
 Network Options 5
 Accessing Care..... 5
 Your DHMP Identification Card..... 5
Getting Care When You Need It..... 6
 Copays and Out-of-Pocket Expenses 6
 Out-of-Pocket Maximums..... 6
 Preventive and Health Maintenance
 Medical Management..... 7
 Hospital Care 7
 Urgent Care Services..... 7
 Emergency Services 7
 Out-of-Area Care 8
 Prior Authorization..... 8
 Vision Care Services..... 9
 Mental Health Services 9
 Chiropractic Care 9
Pharmacy Services 10
 Pharmacy Benefits..... 10
 Participating Pharmacies..... 10
 Formulary 11
 Generic and Brand Name Copays..... 11

Refill Prescriptions 11
 Mail Order Pharmacies..... 12
 DH Pharmacy by Mail 12
 MedVantx 12
 90-Day Supply at retail..... 12
**2012 Colorado Health Benefit Plan
 Description Form 13**
Other Services 21
 Care Support Services..... 21
 Case Management..... 21
 Health & Wellness 21
 Dividends (Special Programs)
 Information 22
Other Things You Should Know..... 24
 Grievances and Appeals 24
 The Difference Between a Grievance
 and an Appeal 24
 How to File a Grievance 24
 How to File an Appeal..... 24
 External Appeal Reviews 24
 Expedited Appeal Reviews 25
 The Division of Insurance 25
 Confidential Information..... 25
 Web Site 25
 Member Services..... 26
 Member Rights and Responsibilities..... 26



Welcome to DHMP

We are pleased you have selected Denver Health Medical Plan, Inc. (DHMP) for your health plan. We are dedicated to good health, starting with you.

In this quick reference guide, you will find an overview of the plan, how it works and a summary of your benefits. Take a few moments to review this guide and keep it handy to answer questions in the future. For more detailed information, check your Member Handbook which is available online at www.denverhealthmedicalplan.com or you may call Member Services at 303-602-2100. Member Services is available to answer all your questions from 8:00 a.m. – 5:00 p.m. Monday – Friday. We look forward to caring for you and your family.

Your Health Network

The DHMP POS plan is a three-tiered plan that allows use of Denver Health Medical Center (DHMC) providers and facilities (Tier 1), DHMP Cofinity contracted providers and facilities (Tier 2), and all other licensed providers and facilities (Tier 3) with higher cost sharing. Deductibles, coinsurance and certain coverage limitations apply to Tiers 2 and 3. See the Colorado Health Benefit Plan Description form later in this guide.

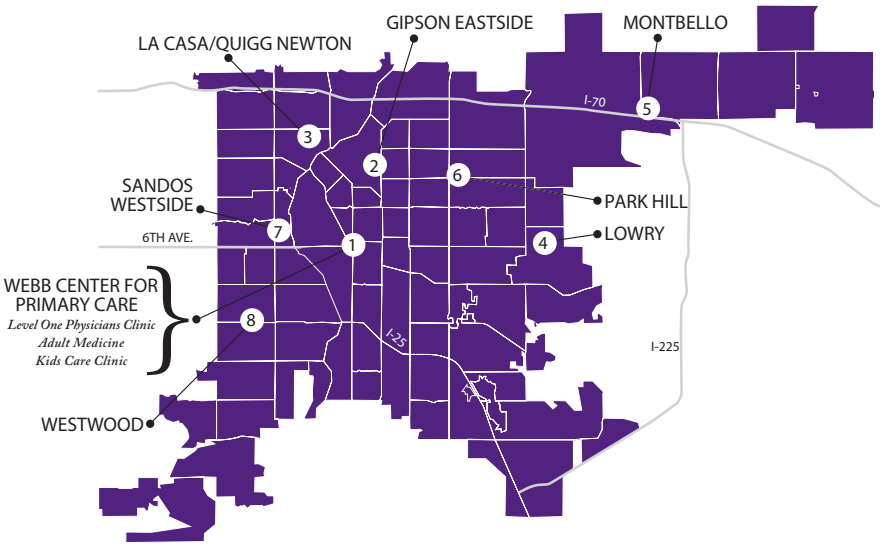
All Denver Health providers are also on the faculty of University of Colorado Hospital.



Your Provider Directories list the physicians, hospitals, urgent care facilities, and specialty providers in Tiers 1 and 2. Your DHMP provider directories (Denver Health Authority, DHMP Cofinity) are available online at www.denverhealthmedicalplan.com. While DHMP will periodically update the provider directories, it is your responsibility to confirm with your provider their participation with the network. Check the DHMP Cofinity provider directory at www.cofinity.net for the most up-to-date listings. Or you may call Member Services at 303-602-2100.



How DHMP Works



FAMILY HEALTH CENTERS

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

LEVEL ONE PHYSICIANS CLINIC 303.602.8270

ADULT MEDICINE CLINIC
Burgundy 303.602.8070
Green Team 303.602.8080

KIDS CARE CLINIC 303.602.8340

Rx PHARMACY 303.602.8500

Rx GIPSON EASTSIDE
501 28th St. 303.436.4600
Pharmacy 303.436.4090

Rx LA CASA/QUIGG NEWTON
4545 Navajo 303.436.8700
Pharmacy 303.436.8700

LOWRY
1001 Yosemite St. 303.436.4545
Suite 100

Rx MONTBELLO
12600 E. Albrook Dr. 303.602.4000
Pharmacy 303.602.4025

PARK HILL
4995 E. 33rd Ave. 303.602.3720

Rx SANDOS WESTSIDE
1100 Federal Blvd 303.436.4200
Pharmacy 303.436.4200

WESTWOOD
4320 W Alaska Ave 720.956.2900

HOSPITAL
DENVER HEALTH MEDICAL CENTER
777 Bannock St. 303.436.6000

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

PEDIATRIC URGENT CARE CLINIC
777 Bannock St. 303.602.3300

● Questions? Call Member Services at 303-602-2100 or toll-free at 1-800-700-8140 ●



Network Options

As a member of DHMP's Point of Service (POS) Plan, you can choose where you receive your health care.

There are 3 tiers of providers you may choose from:

Tier 1: DHMC providers and facilities

Tier 2: DHMP Cofinity contracted providers and facilities

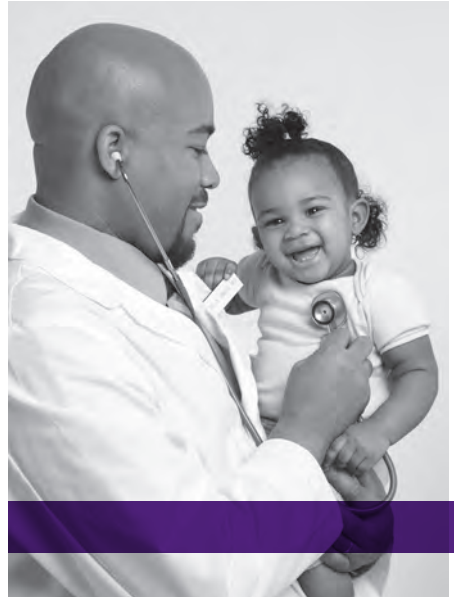
Tier 3: All other licensed providers and facilities (non-network providers)

However, deductibles, coinsurance and coverage limitations apply to Tiers 2 and 3. See the Colorado Health Benefit Plan Description form in this guide for more details.

Accessing Care

Under the POS Plan you are not required to choose a PCP nor are you required to obtain a referral from a PCP for Specialty care outside the DHMC Network. However, if you choose to stay within the DHMC tier, you will need a referral to most DHMC specialists.

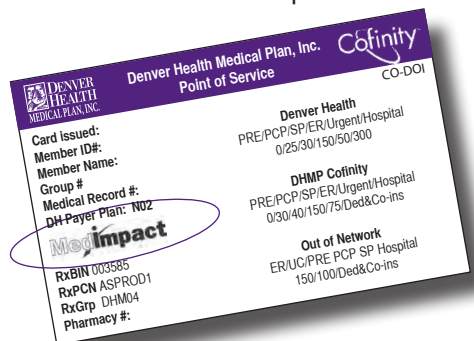
Self referral is allowed in Tier 1 for routine eye exams, OB-GYN, outpatient mental health and chiropractic services received through Columbine Chiropractic.



Your DHMP Identification Card

You, and each member of your family, will receive a new member identification (ID) card for 2012. This card will have a MedImpact logo on it. **As of 1/1/12 you must use this card. If you try to use your old ID card you will not be able to fill prescriptions.**

If you did not receive your new card or have misplaced it, call Member Services at 303-602-2100 for a replacement.





Getting Care When You Need It

Copays and Out-of-Pocket Expenses

The most commonly used copays are listed on the front of your member ID card. Applicable copays are due at the time of service. These copays are also listed in the Health Plan Description form found later in this guide. Detailed information regarding copays can be found in the Member Handbook on our website at www.denverhealthmedicalplan.com.

As a Point of Service (POS) member you are able to choose the tier of service you access for your health care. Out-of-pocket costs will be the least in the DHMC tier. Copays are lower and no deductible or coinsurance will apply.

- Copays, coinsurance amounts and deductibles vary, depending on the tier of the provider that renders the service. A copay is a flat fee you pay for a medical service or item, such as an office visit or a prescription drug. Copays are generally paid at the time you receive the service(s) or item(s).
- Coinsurance amounts are usually stated as a percentage to indicate that the cost of service is shared by you and DHMP. Coinsurance percentages in the Colorado Health Benefit Plan Description form reflect the amount the PLAN will pay. Some services in Tier 2 require both a copay and coinsurance on the remaining charges.
- A deductible is the amount of money you must pay for covered services before DHMP becomes responsible for payment. Deductibles and out of pocket maximums for tiers 2 & 3

accumulate separately. There is no out-of-pocket maximum in the Denver Health tier. Refer to the Colorado Health Benefit Plan Description form for details on copays and other out-of-pocket expenses.

- Certain services may require a both a copay and coinsurance. For instance, if you visit a primary care provider in the DHMP Cofinity tier of service, you pay the \$30 copay. If that provider orders lab work that will be sent to a different facility, deductible and coinsurance would apply to the lab work. However, copayment will cover laboratory and pathology services related to certain preventative services.

Your member handbook contains more detailed information and can be found on our web site at www.denverhealthmedicalplan.com.

Out-of-Pocket Maximums

Your out-of-pocket maximum is the maximum amount of expenses for covered medical services you and all your dependents have to pay each year. There is a separate maximum for each family member until the total family maximum is reached. Each tier of the POS plan has a separate out-of-pocket maximum as well. Therefore, the expenses for a Tier 2 provider will count towards the out-of-pocket maximum for Tier 2; the expenses for a Tier 3 provider count towards the Tier 3 maximum. Refer to the Colorado Health Benefit Plan Description form for details.

Copays, including prescription drug copays, do not apply to any out-of-pocket maximum. Generally, deductible and coinsurance amounts do apply to your out-of-pocket maximum.



Other expenses not included in this maximum are costs for non-covered benefits/services. When accessing services in Tier 3, you may be billed for charges greater than the Usual and Customary amount. These charges are member's responsibility and do not apply to out-of-pocket maximums.

Preventive and Health Maintenance Medical Management

DHMP has developed clinical and preventive care guidelines and health management programs to assist members with common health conditions, including diabetes management, asthma, and pregnancy care. 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. DHMP now offers \$0 copays for preventive services. This \$0 copay does not apply to Tier 3.

For detailed information on preventive care, see your handbook or our web site at www.denverhealthmedicalplan.com.

Hospital Care

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

Urgent Care Services

Urgent care services are covered with different levels of copays corresponding to tiers of coverage. An urgent medical problem is a minor medical emergency that is not life-threatening.

Members may also call the NurseLine at 303-739-1261 for assistance.



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 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 applicable inpatient copayment.

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

Follow-up care following an emergency department visit will be paid according to the tier in which the service is obtained.



Getting Care When You Need It

Out-of-Area Care

DHMP will pay out-of-network providers directly or reimburse you for emergency and certain urgent care services. Routine care accessed out-of-area will be subject to deductible and coinsurance in Tier 3.

Urgent care services received outside the DHMC or DHMP Cofinity Network are covered under the third tier of the Point of Service plan. Deductible and coinsurance will apply.

Following an emergency or urgent care visit outside the DHMC Network, one follow-up visit for that condition is covered. A separate copayment will be required. *Note: Travel expenses back to the DHMC or DHMP Cofinity Network Area are not a covered benefit.*

Prior Authorization

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
- Hospice care

Contact your Primary Care Physician or Specialist to request these services.





Vision Care Services

Routine visual screening examinations are covered once every 24 months, applicable copays or deductible and coinsurance apply. Self referral is allowed in all tiers of service. Eye examinations require the copayment for a “specialty” visit. DHMP offers an eyewear reimbursement of \$200 every 24 months. See your member handbook for detailed information and the eyewear reimbursement form.

Mental Health Services

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 DHMC or DHMP Cofinity Network without a referral from your PCP.

There is no copayment for phone consultations with your mental health provider. See your member handbook for more information and covered services.

Chiropractic Care

Maximum benefit is 20 visits per calendar year. The copay for each visit is \$20. Chiropractic services are only covered through Columbine Chiropractic providers. You may self-refer in network.





Pharmacy Services

Pharmacy Benefits

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

Participating Pharmacies

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

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

- Denver Health Refill Request Line
1-866-347-3345
- Denver Health Pharmacy by Mail (requires credit card registration/order form)
303-602-2326
- Primary Care Pharmacy
303-602-8500
301 West 6th Avenue
- Eastside Pharmacy
303-436-4600
501 28th Street
- ID/HIV Clinic Pharmacy
303-602-8710
605 Bannock Street
- La Casa Pharmacy
303-436-8700
4545 Navajo Street
- Montbello Pharmacy (NEW LOCATION)
303-602-4025
12600 Albrook Drive

Class	Tier 1 Preferred Generic	Tier 2 Preferred Brand	Tier 3 Non-Preferred	Discount Copay List
DHMC Pharmacies (30 days)	\$5	\$15	\$20	\$4
DH by mail (90 days)	\$10	\$30	\$40	\$8
Non-DH Pharmacies	\$15	\$25	\$45 Requires Prior Authorization (PAR)	Not available
MedVantx by mail (90 days)	\$30	\$50	\$90 Requires Prior Authorization (PAR)	Not available

● Questions? Call Member Services at 303-602-2100 or toll-free at 1-800-700-8140 ●



Westside Pharmacy

303-436-4200

1100 Federal Blvd

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

Formulary

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

You can view the current formulary at www.denverhealthmedicalplan.com through the “Members” button or you can call Member Services to request a printed copy.

If a restriction is noted on the formulary or you do not see your drug listed, please talk to your provider. There may be a generic or a formulary approved alternative drug. Your provider may request an exception by calling or submitting a Prior Authorization Request (PAR) to the Managed Care Pharmacy Services Department 303-602-2070 option # 1. All requests are reviewed on a case-by-case basis.

Generic and Brand Copays

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

Refill Prescriptions

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

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



Pharmacy Services

Mail Order Pharmacies

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

- Denver Health Pharmacy by Mail
Offers lower copays
Prescriptions must be written by a DHMC provider
- MedVantx
MedVantx
2503 E 54th St N
Sioux Falls, SD 57104
Phone: (866)744-0621
Website: www.MedVantxinc.com

90-Day Supply at retail

New in 2012 Members will be able to purchase a 90-day supply for certain maintenance medications at designated Choice 90 pharmacies. You will pay 3 copays for each 90-day prescription. You can find out if your drug and/or pharmacy are included by visiting our website at www.denverhealthmedicalplan.com or by calling Member Services.

2012 Colorado Health Benefit Plan Description Form

Denver Health Medical Plan, Inc.

Point of Service Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Point of Service (POS)
2. OUT-OF-NETWORK CARE COVERED? ¹	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available only in the following areas: Denver, Jefferson, Arapahoe, and Adams Counties.

PART B: SUMMARY OF BENEFITS

IMPORTANT NOTE: This form is not a contract. It is only a summary. The contents of this form are subject to the provisions of the policy, 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 pre-authorization, a referral from your primary care physician, or use of specified providers or facilities. Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the PLAN will pay. Deductible and copay are paid by the MEMBER.

	In Network	Cofinity Network	Out-of-Network
4. DEDUCTIBLE TYPE ²	No deductible applies	Calendar year	Calendar year
4a. ANNUAL DEDUCTIBLE ^{2a} a) [Individual] [Single] ^{2b} b) [Family] [Non-single] ^{2c}	a) No deductible applies b) No deductible applies	a) \$400/Member b) OR \$800/Family	a) \$1,500/Member b) \$3,000/Family
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual (Single) b) Family (Non-single) 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.	a) \$1,500 b) OR \$3,000/Family c) Out-of-Pocket maximums include the calendar year deductible and coinsurance, but exclude copay. Pharmacy copay/coinsurance do not apply to the out-of-pocket maximum.	a) \$10,00/Member b) OR \$20,000/Family c) Out-of-Pocket maximums include the calendar year deductible and coinsurance, but exclude copay. Pharmacy co-pays/coinsurance do not apply to the out-of-pocket maximum.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum		

	In Network	Cofinity Network	Out-of-Network
7A. COVERED PROVIDERS	Denver Health and Hospital Authority providers, Columbine Chiropractic, and Denver Health Medical Center. See provider directories for a complete list of providers.	Cofinity; Columbine Chiropractic Plan. See provider directories for a complete list of providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes	Not applicable
8. MEDICAL OFFICE VISITS ⁴ a) Primary Care Providers b) Specialists	a) \$25 copay b) \$30 copay	a) \$30 copay (deductible and coinsurance waived) b) \$40 copay (deductible and coinsurance waived) Lab fees may apply, see your Member handbook for details.	a) Deductible, then Plan pays 50% of usual and customary charges b) Deductible, then Plan pays 50% of usual and customary charges
9. PREVENTIVE CARE a) Children's services b) Adults' services	a) \$0 copay per visit for well-child exams b) \$0 copay per visit for annual preventive care exams and well-woman exams	a) \$0 copay per visit for well-child exams (deductible and coinsurance waived) b) \$0 copay per visit for annual preventive care exams and well-woman exams (deductible and coinsurance waived,)	a) Deductible then Plan pays 50% of usual and customary b) Deductible then Plan pays 50% of usual and customary Immunizations are not covered in this tier. No cost sharing
PREVENTIVE SCREENING • Colonoscopy • Mammogram • All preventive screenings rated A or B by USPSTF See website for full listing	\$0 copay NO cost sharing	\$0 copay (deductible and coinsurance waived) No cost sharing.	\$0 copay (deductible and coinsurance waived) No cost sharing.
10. MATERNITY a) Prenatal care and first post-partum visit b) Delivery & inpatient well baby care ⁵	a) \$5 copay per visit b) \$200 copay per admission	a) \$15 copay per visit (deductible and coinsurance waived) b) Deductible, then Plan pays 80%	a) Deductible, then Plan pays 50% of usual and customary charges b) Deductible, then Plan pays 50% of usual and customary charges

	In Network	Cofinity Network	Out-of-Network
<p>11. PRESCRIPTION DRUGS⁶</p> <p>Level of coverage and restrictions on prescriptions</p> <p>Copay/Coinsurance do not apply to the out-of-pocket maximums or deductible</p>	<p>Denver Health Pharmacy (30-day supply):</p> <p>\$5 generic \$15 brand \$20 non-formulary</p> <p>\$4 for certain maintenance drugs</p> <p>DH Pharm by Mail: (90-day supply):</p> <p>\$10 generic \$30 brand \$40 non-formulary \$8 for certain maintenance drugs</p> <p>Participating pharmacy (30-day supply):</p> <p>\$15 generic \$25 brand \$45 non-formulary</p> <p>For drugs on our approved list, contact Member Services at 303-602-2100</p>	<p>Participating pharmacy (30-day supply):</p> <p>\$15 generic \$25 brand \$45 non-formulary</p> <p>MedVantx (90-day supply):</p> <p>\$30 generic \$50 brand \$90 non-formulary</p> <p>For drugs on our approved list, contact Member Services at 303-602-2100</p>	<p>Not covered in this tier.</p>
12. INPATIENT HOSPITAL	<p>\$300 copay per admission</p> <p>Pre-authorization required.</p>	<p>Deductible, then Plan pays 80%</p> <p>Pre-authorization required.</p>	<p>Deductible, then Plan pays 50% of usual and customary charges (If admitted after emergency care, Preferred Provider deductible applies then Plan pays 80%)</p> <p>Pre-authorization required</p>
13. OUTPATIENT/ AMBULATORY SURGERY	<p>\$100 copay</p> <p>Pre-authorization required.</p>	<p>Deductible, then Plan pays 80%</p> <p>Pre-authorization required.</p>	<p>Deductible, then Plan pays 50% of usual and customary. Pre-authorization required.</p>
14. DIAGNOSTICS			
<p>a) Laboratory & x-ray</p> <p>b) MRI or PET scan</p>	<p>a) No copay (100% covered)</p> <p>b) \$100 copay</p>	<p>a) Deductible, then Plan pays 80%</p> <p>b) \$100 copay (deductible and coinsurance waived)</p>	<p>a) Deductible, then Plan pays 50% of usual and customary charges.</p> <p>b) Deductible, then Plan pays 50% of usual and customary charges.</p>

	In Network	Cofinity Network	Out-of-Network
14A. Special Services (including but not limited to:)	<p>Renal Dialysis: No copay - 100% covered</p> <p>Sleep Study: \$200 copay</p> <p>Radiation Therapy: \$10 copay/visit</p> <p>Infusion Therapy (includes chemotherapy): \$10 copay/visit</p> <p>Injections: \$10 copay/visit (immunizations, allergy shots and other injections given by a nurse are \$0 copay)</p>	<p>Renal Dialysis: No copay - 100% covered. (deductible and coinsurance waived)</p> <p>Sleep Study: \$200 copay (deductible and coinsurance waived)</p> <p>Radiation Therapy: \$10 copay/visit (deductible and coinsurance waived)</p> <p>Infusion Therapy (includes chemotherapy): \$25 copay/visit (deductible and coinsurance waived)</p> <p>Injections: \$25 copay/visit (immunizations, allergy shots and other injections given by a nurse are \$0 copay) (deductible and coinsurance waived)</p>	<p>Renal Dialysis: Deductible and Plan pays 50% of usual and customary charges.</p> <p>Sleep Studies: Deductible, then Plan pays 50% of usual and customary charges.</p> <p>Radiation Therapy: Not covered</p> <p>Infusion Therapy: Not covered in this tier.</p> <p>Injections: Not covered in this tier.</p>
15. EMERGENCY CARE ^{7,8}	\$150 copay per visit (waived if admitted)	\$150 copay per visit (deductible and coinsurance waived, copay waived if admitted)	\$150 copay per visit (deductible and coinsurance waived, copay waived if admitted)
15a. Observation Stay	\$150 copay	\$200 copay (deductible and coinsurance waived)	Deductible, then Plan pays 50% of usual and customary charges.
16. AMBULANCE	\$150 copay per trip (not waived if admitted)	\$150 copay per trip (deductible and coinsurance waived, copay not waived if admitted)	\$150 copay per trip (deductible and coinsurance waived, copay not waived if admitted)
17. URGENT, NON ROUTINE, AFTER HOURS CARE	\$50 copay per visit	\$75 copay per visit (deductible and coinsurance waived)	\$100 copay per visit (deductible and coinsurance waived)
18. BIOLOGICALLY-BASED MENTAL ILLNESS AND MENTAL DISORDERS CARE ⁹	<p>a) Inpatient: \$300 copay. Pre-authorization required.</p> <p>b) Outpatient: \$0 copay per visit.</p>	<p>a) Inpatient: Deductible, then Plan pays 80%. Pre-authorization required.</p> <p>b) Outpatient: \$0 copay per visit. (deductible and coinsurance waived)</p>	<p>a) Inpatient: Deductible, then Plan pays 50% of usual and customary charges. Pre-authorization required.</p> <p>b) Outpatient: Deductible, then Plan pays 50% of usual and customary charges.</p>

	In Network	Cofinity Network	Out-of-Network
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) Inpatient: \$300 copay. Pre-authorization required. b) Outpatient: \$0 copay per visit.	a) Inpatient: Deductible, then Plan pays 80%. Pre-authorization required. b) Outpatient: \$0 copay per visit. (deductible and coinsurance waived)	a) Inpatient: Deductible, then Plan pays 50% of usual and customary charges. Pre-authorization required. b) Outpatient: Deductible, then Plan pays 50% of usual and customary charges.
20. ALCOHOL & SUBSTANCE ABUSE If not covered under #18 above as a mental disorder)	a) Detoxification: \$300 copay. b) Inpatient: \$300 per admission. Pre-authorization required. c) Outpatient: \$0 copay per visit (deductible waived).	a) Detoxification: Deductible then Plan pays 80%. b) Inpatient: Deductible then Plan pays 80%. Pre-authorization required. c) Outpatient: \$0 copay per visit (deductible and coinsurance waived)	a) Detoxification: Deductible, then Plan pays 50% of usual and customary charges. b) Inpatient: Deductible, then Plan pays 50% of usual and customary charges. c) Outpatient: Deductible, then Plan pays 50% of usual and customary charges.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	\$10 copay/visit. Maximum benefit is 20 visits per calendar year per type of therapy.	Deductible, then Plan pays 80%. Maximum benefit 20 visits per calendar year per type of therapy..	Deductible, then Plan pays 50% of usual and customary charges. Maximum benefit 20 visits per calendar year per type of therapy
22. DURABLE MEDICAL EQUIPMENT	Plan pays 80%; maximum benefit is \$2,000 per calendar year; authorization required.	Plan pays 80%; maximum benefit is \$2,000 per calendar year; authorization required.	Not covered in this tier.
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 no longer apply to the annual DME limit.		Not covered in this tier.
22b. PROSTHETICS	Plan pays 80% of cost. No maximum benefit, does not apply to DME annual limit.	Plan pays 80% of cost. No maximum benefit, does not apply to DME annual limit.	Not covered in this tier.
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.		

	In Network	Cofinity Network	Out-of-Network
23. OXYGEN/OXYGEN EQUIPMENT	No copay (100% covered); Equipment: 20% coinsurance, does not apply to DME maximum	No copay (100% covered) (Deductible and coinsurance waived) Equipment: 20% coinsurance, does not apply to DME maximum	Deductible, then Plan pays 50% of usual and customary charges. Equipment: 50% coinsurance, does not apply to DME maximum
24. ORGAN TRANSPLANTS	\$350 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. Pre-authorization required.		Not covered in this tier.
25. HOME HEALTH CARE	No copay (100% covered) for prescribed medically necessary skilled home health services. Pre-authorization required.	Deductible, then 100% covered. Pre-authorization required.	Deductible, then Plan pays 50% of usual and customary charges. Pre-authorization required.
26. HOSPICE CARE	No copay (100% covered). Pre-authorization required.	Deductible, then 100% covered. Pre-authorization required.	Deductible, then Plan pays 50% of usual and customary charges. Pre-authorization required.
27. SKILLED NURSING FACILITY CARE	No copay (100% covered). Maximum benefit is 100 days per calendar year at authorized facility. Pre-authorization required.	Deductible, then 100% covered. Maximum 100 days per calendar year at authorized facility. Pre-authorization required.	Deductible, then Plan pays 50% of usual and customary charges. Pre-authorization required. Maximum 100 days per calendar year at authorized facility.
28. DENTAL CARE	Not covered except for fluoride varnish at PCP visit.		
29. VISION CARE	\$30 copay per visit for routine eye exams.	\$40 copay per visit for routine eye exams (deductible and coinsurance waived.)	Routine eye exam not covered.
	Limit of one routine eye exam every 24 months. Self-referral allowed in network.		
	<ul style="list-style-type: none"> • Eyewear • Plan pays up to \$200 one time per 24 month period for prescription eyewear. • *Only one claim can be submitted in a 24 month period, i.e. if you are using the benefit for contacts, you may want to wait until you have accumulated \$200 in charges before submitting a claim in order to use full benefit. • \$200 toward Lasik surgery once per lifetime. This benefit can be used at any time regardless of whether or not the \$200/24-month benefit has been used. Deductible waived. 		

	In Network	Cofinity Network	Out-of-Network
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	<p>Autism Services: Expanded services will be available with cost sharing based on type of service.</p> <p>Cochlear implants are now covered for children under age 18. The device is covered at 100%, applicable inpatient/out-patient surgery charges will apply.</p> <ul style="list-style-type: none"> • 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 Savings. Special pricing plus a 35% subsidy towards plan of your choice. • 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. 		None

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.

Form No: COM_MKT_102_00

Revised 08_2011



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 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 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 deductible or copayment, depending on the contract for that plan. The specific deductible or copayment 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.



Care Support Services

Health care navigators are available Monday – Friday, 8 a.m. - 5 p.m. to assist members with all aspects of receiving care in the Denver Health network. They are a complement to the Member Services department and work with members whose needs may be more detailed and clinical in nature. Staff help members maximize health care benefits and reduce barriers that keep them from getting necessary services. They make referrals to programs and specialists in Case Management, Health and Wellness or Pharmacy for additional assistance as needed.

Case Management

Our case managers are available to help you manage your health. Our team of case managers includes nurses, social workers and other trained professionals. We know it can be hard to understand everything that needs to be done to manage your health but we're here to help. We take your health personally and offer services that are focused on you and your needs.

Case managers can assist you with approvals for medically necessary services including durable medical equipment (DME), home health, medical supplies, outpatient therapies and specialty care. Short-term support is available after a hospitalization or change in care.

Complex case managers are available if you have complex medical and social issues and require more intense support. Here are a few ways complex case managers can help you:

- Support to reach health care goals
- Better understand health conditions and concerns

- Coordinate care with primary and specialty providers
- Understand options so you can make better decisions
- Access community resources

Case management services are offered at no cost for all members with Denver Health insurance plans. Our services are voluntary and do not affect your health plan benefits. To speak with a case manager, please call Care Support Services at 303-602-2070, Option 2.

Health & Wellness

Health Coaching is a no-cost program offered through the Health and Wellness Services department. Our health coaches help members take a more active role in their health care and control of illness. They help boost motivation by encouraging and supporting members in making lifestyle changes to improve their health.

Health Coaches can help you with:

- Starting an exercise program
- Eating better/losing weight
- Stopping smoking
- Lowering stress
- Taking your medications
- Community resources

Health Coaches can help you control:

- Asthma
- Diabetes
- COPD
- Congestive Heart Failure
- Depression

To speak with a Health Coach, please call Care Support Services at 303-602-2070, Option 2.



Other Services

Dividends (Special Programs) Information



Healthy Heroes Club

Healthy living can start at any age and it's never too early to teach children how to be healthy and safe. DHMP offers the Healthy Heroes Club for children ages 3-12 as a fun way to encourage these habits.



Children in this age group receive Healthy Heroes materials: Healthy Heroes Membership Card and Certificate; Activity Sheets; Health Tips Postcards and special newsletters mailed to them quarterly. With three different Healthy Hero groups, this program is designed to grow with your child: Explorers (ages 3-6); Rangers (ages 7-9); X-Kidz (ages 10-12).

Acupuncture and Massage Therapy

DHMP now offers a discount program for Acupuncture and Massage Therapy, this is not a plan benefit. Providers participating in this program are at the back of the Provider Directory which can be found on our web site at www.denverhealthmedical-plan.com. There is no limit on visits, each visit is \$40. Simply present your ID card to take advantage of this discount.

Providers may have different definitions for "visit," it could be 30 minutes, 45 minutes or 1 hour. Check with specific provider for details.

Weight Watchers®

DHMP has teamed with Weight Watchers® to bring our members effective weight management offerings at a special price.

Not only does this offer include special prices but in addition DHMP offers subsidy of 35% to all members who join Weight Watchers®. There are four Weight Watchers® options:

- At Work meetings
- Local Meeting vouchers
- Online subscription
- At Home kit

You pick the option that best suits your lifestyle.

To sign up for the special pricing and the 35% subsidy, you must first call Member Services at 303-602-2100 and request a Weight Watchers® code. Once you have the code call Weight Watchers® at this special DHMP member number, 866-442-9178. A Weight Watchers® representative will assist you in signing up for the option you choose.

There is a different process for choosing the Online subscription. You will still need to contact Member Services to request your Weight Watchers® code. For more information, go directly to the online sign up page at www.weightwatchers.com/signup. Enter your promotion code and click "update pricing" to get the special DHMP subscription rate. Choose the subscription length you wish to purchase (3 month or 12 month). Following the remaining instructions to set up your personal account.

If you have questions about Weight Watchers®, call 1-866-442-9178.

● Questions? Call Member Services at 303-602-2100 or toll-free at 1-800-700-8140 ●



Jenny Craig Discount

DHMP has teamed with Jenny Craig® to bring our members effective weight management offerings at a special discount.

To receive 25% reimbursement (up to \$150/month) for monthly costs at Jenny Craig member must:

- Make payment directly to Jenny Craig;
- Fill out Reimbursement form found on website at www.denverhealthmedicalplan.com or at the back of member handbook;
- Mail form and receipt to address on form, and
- Reimbursement will be mailed to member within 30 days.

Member may submit for reimbursement one time each month.

Since 1983, Jenny Craig® has helped millions achieve their weight loss goals with a safe, comprehensive, scientifically-proven program.

- Weekly scheduled one-on-one consultations with a trained consultant at one of 570 Jenny Craig Centres or through Jenny Craig At Home
- Planned and personalized menus
- Daily menu options include a variety of Jenny's Cuisine® items, plus your own added fresh fruits, vegetables, low-fat dairy, whole grains and heart-healthy fats
- Online support and free etools at jennycraig.com
- Customer care phone support through 1-800-JennyCare

Curves Discount

DHMP has partnered with Curves to offer a wellness subsidy for members who workout at Curves at least 8 times each month.

The way the program works:

- Go to the Curves location that you would like to join
- Show them your DHMP member ID and photo ID.
- Curves staff will automatically sign you up for the program.

You will pay your monthly fee as usual. If you workout at Curves at least 8 times in any given month, the bank account that you use to pay your Curves dues will be credited \$20. This will happen for every month that Curves has a record of 8 or more workouts.

If you are currently a member of Curves through our discount program, you will need to discontinue that program in order to join the wellness subsidy program.



Other Things You Should Know

GRIEVANCES AND APPEALS

The Difference Between a Grievance and an Appeal

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

How to File a Grievance

You may file a Grievance by writing or calling Member Services at 303-602-2100 or 800-700-8140, or you can put your Grievance in writing by completing Attachment A at the end of your Member Handbook. If you are unable to make the Grievance yourself, you may assign a person to act on your behalf, by completing the Designation of Client Representative (DCR) form. (Please see Attachment C in your handbook) Please mail your Grievance to the following address:

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

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

How to File an Appeal

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

External Appeal Reviews

External review is available only for adverse decisions in the Appeal process where you have gone through at least one level of Appeal review. You or an authorized representative must send a written request for an external review to the Appeals department within 60 calendar days after you receive the result of your first or second level Appeal to the following address:

DHMP Appeals Department
777 Bannock St., MC 6000
Denver, CO 80204-4507



External review is provided at no cost to you and is arranged by the Colorado Division of Insurance. The Division will assign an independent external review agency to perform a thorough review of your Appeal. You will receive a decision from the external review agency within 30 calendar days of its receipt of your request. Expedited external reviews are available if necessary.

Expedited Appeal Reviews

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

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

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 DCR form. This form is available on our web site at www.denverhealthmedicalplan.com, or you may call Member Services and request it to be mailed to you.

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

Web Site

www.denverhealthmedicalplan.com

Our web site is always expanding to provide you with more information about DHMP, your benefits, physicians and health information. Visit the web site regularly for updates.



Other Things You Should Know

Member Services

We want you to be satisfied with the care and services you receive through DHMP. If you are having any difficulty, please let us know right away so that we can assist you promptly.

You can call Member Services from 8:00 a.m. to 5:00 Monday through Friday at 303-602-2100. You can also visit our web site at: www.denverhealthmedicalplan.com, click on the Members button, click on the Members Home tab and scroll down to "Contact Us." Our representatives are specially trained to:

- Answer questions about your health network
- Provide additional information about how to receive services
- Answer questions about your benefits
- Check eligibility
- Complete address, phone number or PCP changes
- Send you a variety of information upon request.

Spanish and other translations are available upon request.

Member Rights and Responsibilities

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

DHMP is committed to partnering with you and your doctor. We will:

- Maintain your personal privacy. Keep your medical records confidential as required by law;

- Provide 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; and
- Provide 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.

In addition, members have a right to:

- Receive information about DHMP, its services, its practitioners and providers, clinical guidelines, and members' rights and responsibilities. This includes how to get services during regular hours, emergency care, after-hours care, out-of-area care, exclusions, and limits on covered service;
- Be treated with respect and recognition of their dignity and right to privacy;
- Timely access to care;
- Participate with practitioners in making decisions about your health care;
- A candid discussion of appropriate or medically necessary treatment options for their conditions. Regardless of cost or benefit coverage. DHMP does not provide physicians or other health care providers with any incentives or disincentives including financial for providing or not providing services;
- Voice complaints or appeals about DHMP or the care provided;
- Make recommendations regarding DHMP's members' rights and responsibilities policies;



- Personal privacy. DHMP will keep your medical records confidential as required by law;
- Change your doctor by calling the DHMP Member Services department;
- Get copies of your medical records or limit access to these records, according to state and federal law;
- Get information about your doctor;
- Request information about the DHMP organization and operations;
- Refuse care from any doctor;
- Ask for a second opinion, at no cost to you;
- Prepare an advance directive;
- Get help from the Division of Insurance office about covered services, benefits, or complaints;
- Provide input on DHMP member rights and responsibilities;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, in accordance with federal regulations. This means that your doctor cannot restrain or seclude you because it is the easiest thing to do. The doctor cannot make you do something that you do not want to do. The doctor cannot try to get back at you for something that you may have done; and
- When you exercise these rights, you will not be treated differently.

YOU are responsible for:

- Supplying information (to the extent possible) needed by DHMP and its practitioners and providers in order to provide care.
- Following plans and instructions for care that have been agreed on with your practitioners.
- Keeping scheduled appointments, canceling or changing the appointment by notifying the provider office (if possible) seventy-two hours in advance.
- Understanding their health problems and participate in developing mutually agreed-upon goals to the degree possible.
- Telling us about other health insurance that you have.



**DENVER
HEALTH**

Medical Plan, Inc.

777 Bannock St., MC 6000

Denver, CO 80204

Member Services: 303-602-2100

www.denverhealthmedicalplan.com