2010 Colorado Health Benefit Plan Description Form
Denver Health Medical Plan, Inc.
Denver Medical Care
Denver Health Authority (DHA)

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 **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.

	In-Network	Out-of-Network
4. DEDUCTIBLE TYPE[2]	No deductible applies	No deductible applies
4a. ANNUAL DEDUCTIBLE[2a] a) [Individual] [Single][2b] b) [Family] [Non-single][2c]	a) No deductible applies b) No deductible applies	Not covered
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 directories for a complete list of providers.	Not covered
7B. With respect to network plans, are all of 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[4] a) Primary Care Providers b) Specialists	a) $20 copay b) $30 copay	Not covered
9. PREVENTIVE CARE a) Children b) Adult	a) $5 copay per visit for well-child exams b) $5 copay per visit for annual preventive care exams $5 copay per visit for well-woman exams • $0 colonoscopy/sigmoidoscopy • $0 annual screening mammography • $0 cervical cancer screening • $0 annually lipid profile • Immunizations: No cost for injection only; if part of an office visit, office visit copay will apply	Not covered
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	Not covered
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions Copay/Coinsurance do not apply to the out-of-pocket maximums or deductible	***Denver Health Pharmacy*** ***(30-day supply)*** $5 generic $15 brand $20 non-formulary $4 for certain maintenance medications to treat diabetes, asthma, blood pressure, and cholesterol. ***Denver Health Pharmacy by Mail*** (90-day supply) $10 generic $30 brand $40 non-formulary $8 for certain maintenance medications to treat diabetes, asthma, blood pressure, and cholesterol. ***Participating Pharmacy*** ***(30-day supply)*** $15 generic $25 brand $45 non-formulary For drugs on our approved list, contact Member Services at 720-956-2100	Not covered
12. INPATIENT HOSPITAL	$300 copay per admission Pre-authorization required. Lifetime maximum on surgical treatment of morbid obesity once per lifetime.	Not covered
13. OUTPATIENT/ AMBULATORY SURGERY	$100 copay Pre-authorization required.	Not covered

	In-Network	Out-of-Network
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI or PET scan	a) No copay (100% covered) b) $50 copay	Not covered
14a. SPECIAL SERVICES (including but not limited to:)	**Renal Dialysis:** No copay – 100% covered **Sleep Study:** $200 copay **Radiation Therapy:** $10 copay/visit **Infusion Therapy (includes chemotherapy):** $10 copay per visit **Injections:** $10 copay (excluding immunizations and allergy shots)	Not covered
15. EMERGENCY CARE[7, 8]	$100 copay per visit (waived if admitted)	$100 copay per visit (waived if admitted)
15a. OBSERVATION STAY	$150 copay	$150 copay
16. AMBULANCE	$150 copay per trip (not waived if admitted)	$150 copay per trip (not waived if admitted)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$30 copay per visit	$50 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS AND MENTAL DISORDERS CARE[9]	Coverage is no less extensive than the coverage provided for any physical illness (appropriate copays apply).	Coverage is no less extensive than the coverage provided for any physical illness (appropriate copays apply).
19. OTHER MENTAL HEALTH CARE a) Inpatient Care b) Outpatient Care	a) Inpatient: $300 copay. Pre-authorization required. b) Outpatient: $30 copay per visit.	Not covered
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 above as a mental disorder)	a) Detoxification: $300 copay. Pre-Authorization is required. b) Inpatient: $300 per admission. Pre-authorization required. c) Outpatient: $30 copay per visit.	Not covered
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	$10 copay per visit. Maximum benefit is 20 visits per calendar year per type of therapy.	Not covered
22. DURABLE MEDICAL EQUIPMENT	Plan pays 80%; maximum benefit is $2,000 per calendar year, authorization required.	Not covered

	In-Network	Out-of-Network
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. Does not apply to the annual DME limit.	Not covered
22b. PROSTHETICS	Plan pays 80% of cost. No maximum benefit, does not apply to DME annual 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.	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/OXYGEN EQUIPMENT	No copay (100% covered); Equipment: 20% coinsurance, does not apply to DME maximum.	Not covered
24. ORGAN TRANSPLANTS	$350 copay per admission. Only covered at authorized facilities. Lifetime maximum of two transplants per individual. 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
25. HOME HEALTH CARE	No copay (100% covered) for prescribed medically necessary skilled home health services. Pre-authorization required.	Not covered
26. HOSPICE CARE	No copay (100% covered). Pre-authorization required.	Not covered
27. SKILLED NURSING FACILITY CARE	No copay (100% covered). Maximum benefit is 100 days per calendar year at authorized facility. Pre-authorization required.	Not covered
28. DENTAL CARE	Not covered	Not covered

<table>
<tr><th></th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td rowspan="2">29. VISION CARE</td><td>$30 copay per visit for routine eye exams. Limit of one routine eye exam every 24 months. Self-referral allowed in network.</td><td>Eye exam not covered</td></tr>
<tr><td colspan="2">Eye wear
Plan pays one time per 24 month period, up to $200 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.</td></tr>
<tr><td>30. CHIROPRACTIC CARE</td><td>$20 copay per visit. Maximum 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.</td><td>Not covered</td></tr>
<tr><td>31. SIGNIFICANT ADDITIONAL COVERED SERVICES</td><td>Cancer screenings as described in the Preventive and Health Maintenance Medical Management Section of the Member Handbook including breast, prostate, and colorectal cancer screening.
Cochlear implants are now covered for children under age 18. The device is covered at 100%, applicable inpatient/ outpatient surgery charges will apply.
• Expanded 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.
• New Weight Watchers Savings. Special pricing plus a 35% subsidy towards plan of your choice.
• New eLearning module for parents-to-be. Online childbirth classes, free of charge to members.</td><td>Not covered</td></tr>
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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 than 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.

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

Durable medical equipment, genetic testing, home health care, including IV therapy; all hospital stays, including alcohol or substance abuse-related stays, outpatient surgery, except those procedures performed in a physician's office, non-formulary medications, skilled nursing facilities, transplant evaluations and procedures and hospice. Contact your Primary Care Physician or Specialist to request these services along with the Medical Necessity.