

2012 Colorado Health Plan Benefit Description Form
Denver Health Medical Plan, Inc.
Point of Service (POS) Plan
Denver Health and Hospital Authority

Part A: TYPE OF COVERAGE

1. TYPE OF PLAN	Point of Service (POS)
2. OUT-OF-NETWORK CARE COVERED?	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. (This refers to where the employer offering the plan is located not where the members live.)

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	Out-of-Network
4. DEDUCTIBLE TYPE²	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 Employee Only b) \$800 Employee & Child(ren) OR \$800 Employee & Spouse OR \$800 Family	a) \$1,500 Employee Only b) \$3,000 Employee & Child(ren) OR \$3,000 Employee & Spouse OR \$3,000 Family
5. OUT-OF-POCKET ANNUAL MAXIMUM³ 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 Employee Only b) \$3,000 Employee & Child(ren) OR \$3,000 Employee & Spouse 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) \$10,000 Employee Only b) \$20,000 Employee & Child(ren) OR \$20,000 Employee & Spouse 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		
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.

	In-Network	Cofinity	Out-of-Network
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 VISITS⁴ 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.
PREVENTIVE SCREENING • Colonoscopy • Mammogram • All preventive screenings rated A or B by USPSTF	\$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
11. PRESCRIPTION DRUGS⁶ 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 drugs DH Pharm by Mail: (90-day supply): \$10 generic \$30 brand \$40 non-formulary \$8 for certain maintenance drugs Participating pharmacy (30-day supply): \$15 generic \$25 brand \$45 non-formulary	Participating pharmacy (30-day supply): \$15 generic \$25 brand \$45 non-formulary Caremark by mail (90-day supply): \$30 generic \$50 brand \$90 non-formulary For drugs on our approved list, contact Member Services at 303-602-2100	Not covered in this tier.
	For drugs on our approved list, contact Member Services at 303-602-2100		

	In-Network	Cofinity	Out-of-Network
12. INPATIENT HOSPITAL	\$300 copay per admission Pre-authorization required. Maximum on surgical treatment of morbid obesity of once per lifetime.	Deductible, then Plan pays 80% Pre-authorization required. Maximum on surgical treatment of morbid obesity of once per lifetime.	Deductible, then Plan pays 50% of usual and customary charges (If admitted after emergency care, Preferred Provider deductible applies then Plan pays 80%) Pre-authorization required Maximum on surgical treatment of morbid obesity of once per lifetime.
13. OUTPATIENT/AMBULATORY SURGERY	\$200 copay Pre-authorization required.	Deductible, then Plan pays 80% Pre-authorization required.	Deductible, then Plan pays 50% of usual and customary. Pre-authorization required.
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI or PET scan	a) No copay (100% covered) b) \$100 copay	a) Deductible, then Plan pays 80% b) \$100 copay (deductible and coinsurance waived)	a) Deductible, then Plan pays 50% of usual and customary charges. b) Deductible, then Plan pays 50% of usual and customary charges.
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/visit Injections: \$10 copay/visit (excluding immunizations, allergy shots and other injections given by a nurse)	Renal Dialysis: No copay - 100% covered. (deductible and coinsurance waived) Sleep Study: \$200 copay (deductible and coinsurance waived) Radiation Therapy: \$10 copay/visit (deductible and coinsurance waived) Infusion Therapy (includes chemotherapy): \$25 copay/visit (deductible and coinsurance waived) Injections: \$25 copay/visit (excluding immunizations, allergy shots and other injections given by a nurse) (deductible and coinsurance waived)	Renal Dialysis: Deductible and Plan pays 50% of usual and customary charges. Sleep Studies: Deductible, then Plan pays 50% of usual and customary charges. Radiation Therapy: Not covered Infusion Therapy: Not covered in this tier. Injections: Not covered in this tier.
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)

	In-Network	Cofinity	Out-of-Network
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 CARE⁹	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.
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.

	In-Network	Cofinity	Out-of-Network
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/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. Limit of one routine eye exam every 24 months. Self-referral allowed in network.	\$40 copay per visit for routine eye exams (deductible and coinsurance waived.) Limit of one routine eye exam every 24 months. Self-referral allowed in network.	Routine eye exam not covered.
	Eyewear Plan pays up to \$200 one time per 24 month period for prescription eyewear. <i>*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.</i> \$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	Out-of-Network
30. CHIROPRACTIC CARE	\$20 copay per visit. Maximum 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	\$20 copay per visit. Maximum 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered in this tier.
	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.		
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/outpatient surgery charges will apply.</p> <ul style="list-style-type: none"> • 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 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 • Snap Fitness discount. • eLearning module for parents-to-be. Online childbirth classes, free of charge to members. 		

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 is available immediately upon request or see 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	Not covered
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_102-00	
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 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 covered 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 No. 9 below.
- 5 Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital co payment applies to mother and well baby together; there are not separate copayments unless mom 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 grievances procedures. Write the Colorado Division of Insurance for a copy of these procedures.

Prior 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 and provide the Medical Necessity information.

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.