2012 Colorado Health Plan Benefit Description Form
Denver Health Medical Plan, Inc.
Denver Medical Care
CSA and DERP Non-Medicare Primary

Part A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health Maintenance Organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for emergency and urgent care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available **only** in the following areas: Denver, Jefferson, Arapahoe and Adams counties. (This refers to the employer offering the plan 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 Member Handbook, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the Member Handbook to determine the exact terms and conditions of coverage. Copayment options reflect the amount the covered person will pay.

	In-Network	Out-of-Network
4. DEDUCTIBLE TYPE[2]	Not applicable.	Not applicable.
4a. ANNUAL DEDUCTIBLE[2a] **a) [Individual] [Single][2b]** **b) [Family] [Non-single][2c]**	Not applicable.	Not applicable
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	No out-of-pocket maximum
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	Not covered
7A. COVERED PROVIDERS	Denver Health and Hospital Authority providers, Columbine Chiropractic, and Denver Health Medical Center. See provider directory for a complete list of current providers.	Not covered
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes.	Not applicable

	In-Network	Out-of-Network
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**	a) $35 copay b) $50 copay	Not covered
9. PREVENTIVE CARE **a) Children** **b) Adults**	a) $0 copay b) $0 copay	Not covered
Preventive screenings including but not limited to: **Colo-rectal screening** **Mammograms** **Lipid Disorders** **Osteoporosis** ***Includes all preventive care according to US Preventive Task Force A and B items.***	$0 copay	Not covered
10. MATERNITY **a) Prenatal care** **b) Delivery & inpatient well baby care[5]**	a) $35 copay per visit b) $500 copay per admission	Not covered
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions**	***If prescription is filled at a Denver Health Pharmacy (30-day supply):*** $15 copay for generic $25 copay for brand name drugs $45 copay for non-formulary drugs $8 copay for certain maintenance drugs to treat diabetes, asthma, blood pressure and cholesterol. ***Denver Health Pharmacy Delivery by Mail (90-day supply):*** $30 copay for generic $50 copay for brand name drugs $90 copay for non-formulary drugs $16 copay for certain maintenance drugs to treat diabetes, asthma, blood pressure and cholesterol. ***If prescription filled at a non-Denver Health Pharmacy (30-day supply):*** $25 copay per prescription for generic drugs $45 copay per prescription for brand name drugs $65 copay per prescription for non-formulary drugs For drugs on our approved list, contact Member Services at (303) 602-2100.	Not covered
12. INPATIENT HOSPITAL	$1,000 copay per admission Pre-authorization required	Not covered
13. OUTPATIENT/ AMBULATORY SURGERY	$350 copay Pre-authorization required	Not covered

	In-Network	Out-of-Network
14. DIAGNOSTICS **a) Laboratory & x-ray** **b)** MRI or PET scan	a) $0 copay b) $200 copay	Not covered
14a. OTHER DIAGNOSTIC AND THERAPEUTIC SERVICES **a) Sleep study** **b) Radiation therapy** **c) Infusion therapy (includes chemotherapy)** **d) Injections** **e) Renal dialysis**	a) $400 copay b) $10 copay per visit c) $10 copay per visit d) $20 copay (immunizations and other injrections given by a nurse are $0 copay) e) Covered at 100%	Not covered
15. EMERGENCY CARE[7, 8]	$300 copay per visit (waived if admitted)	$300 copay per visit (waived if admitted)
15a. OBSERVATION STAYS	$300 copay (copay waived if admitted)	$300 copay (copay waived if admitted)
16. AMBULANCE	$450 copay per trip (<u>not</u> waived if admitted)	$450 copay per trip (<u>not</u> waived if admitted)
17. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$100 copay per visit	$100 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	a) Inpatient: $1,000 copay per admission. Pre-authorization required. b) Outpatient: $50 copay per visit.	Not covered
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	a) Inpatient: $1,000 copay per admission. Pre-authorization required. b) Outpatient: $50 copay per visit.	Not covered
20. ALCOHOL & SUBSTANCE ABUSE (If not included under #18 above as a mental disorder)	a) Detoxification: $1,000 copay per admission. Pre-authorization required. b) Inpatient: $1,000 copay per admission. Pre-authorization required. c) Outpatient: $50 copay per visit.	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$50 copay per visit. Maximum benefit is 20 visits per calendar year per type of therapy.	Not covered
22. DURABLE MEDICAL EQUIPMENT	Plan pays 70%; maximum benefit is $2,000 per calendar year, prior authorization required.	Not covered

	In-Network	Out-of-Network
22a. HEARING AIDS	Plan pays for medically necessary hearing aids not more frequently than every 5 years. For minors under age 18, plan pays 100%. For adults age 18 and over, plan pays up to $1,000 maximum. Prior authorization required. *(This does not apply to the Durable Medical Equipment maximum benefit of $2,000 per calendar year.)*	Not covered
22b. PROSTHETICS	Plan pays 70%. No maximum benefit, does not apply to annual DME limit.	Not covered
22c. ORTHOTICS	Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but you must pay out-of-pocket and submit receipt for reimbursement.	Not covered
23. OXYGEN/OXYGEN EQUIPMENT	100% covered. Equipment covered at 70%.	Not covered
24. ORGAN TRANSPLANTS	$1,000 copay per admission/individual plus deductible. Only covered at authorized facilities. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants. Pre-authorization required.	Not covered
25. HOME HEALTH CARE	$50 copay per visit for prescribed medically necessary skilled home health services. Pre-authorization required.	Not covered
26. HOSPICE CARE	100% covered. Pre-authorization required.	Not covered
27. SKILLED NURSING FACILITY CARE	100% covered. Maximum 100 days per calendar year at authorized facility. Pre-authorization required.	Not covered
28. DENTAL CARE	Not covered.	Not covered
29. VISION CARE	Routine eye exams are not covered. (Non-routine opthalmologist appointments are covered as a specialist visit.)	Not covered
30. CHIROPRACTIC CARE	$20 copay per visit. Maximum benefit is 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered

	In-Network	Out-of-Network
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Cochlear implants are now covered for children under age 18. The device is covered at 100%, applicable inpatient/ outpatient surgery charges will apply. Autism: Expanded services will be available with cost sharing based on type of service. Additional Benefits: • **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. • **Jenny Craig** discount; members receive a discount on enrollment and 25% off monthly program cost. • **Snap Fitness discount** • **Weight Watchers Savings.** DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • **eLearning module for parents-to-be.** Online childbirth classes, free of charge to members.	None

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-101-00	
43. Does the plan have a binding arbitration clause?	No	

Endnotes

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

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

2a A "Deductible" means the amount 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 deducible 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 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 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 Physical or Specialist to request these services along with the Medical Necessity.

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 303-602-2l00.