DENVER HEALTH MEDICAL PLAN, INC

Draft Rate Sheets, Summary of 2013 Benefit Changes & Summary of 2013 Benefits

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DENVER HEALTH
Medical Plan, Inc.

August 16, 2012

Bruce Backer
Career Services Authority
Department 412 (4th Floor)
201 W. Colfax Ave.
Denver, CO 80202

Dear Bruce,

Below you will find the final rates for 2013. DHMP will offer two health benefit plans. The first is the current HMO model with several benefit enhancements included. The second is a Deductible HMO matching benefits to the United Healthcare Navigate plan. The Division of Insurance has approved these rates. There is no assessment for Cover Colorado in 2013.

It is our understanding that both plans will be offered not only to the Career Service Authority (CSA) and the Denver Employer Retirement Plan (DERP) but also to the Police Protective Association (PPA).

2013 HMO rates with 2% increase, benefit enrichments

Denver Health Medical Plan, Inc. Draft Rates for Calendar Year 2013 DOI Approval	
Employee	$515.73
Employee & Spouse	$1,074.91
Employee & Child(ren)	$833.57
Employee and Family	$1,490.46

Benefit Changes	2012	2013
PCP/Specialist visits ($0 for preventive care)	$35/50 copay/visit	$25/40 copay/visit
Outpatient Surgery	$350 copay/surgery	$200 copay/surgery
Inpatient Stays	$1,000 copay/stay	$500 copay/stay
Emergency room/observation	$300 copay/visit	$150 copay/visit
Urgent Care	$100 copay/visit in or out of network	$50 copay/visit in network $100 copay/visit out of network
Maternity	$500 copay/stay $35 copay/visit	$300 copay/delivery; $25 copay/visit

2013 Deductible HMO rates

Denver Health Medical Plan, Inc. Draft Rates for Calendar Year 2013 DOI Approval	
Employee	$438.22
Employee & Spouse	$913.37
Employee & Child(ren)	$708.31
Employee and Family	$1,266.48

If you have any questions or need additional information please contact me at 303-602-2065 or Laurie.Goss@dhha.org.

Sincerely,

Laurie Goss
Commercial Program Manager

12-025

2013 Colorado Health Benefit Plan Description Form
Denver Health Medical Plan, Inc.
Denver Health Medical Care
Police Protective Association

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

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

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

	In Network	Out-of-Network
9. **PREVENTIVE CARE SERVICES** a) **Children** b) **Adults**	a) $0 copay per visit for well-child exams b) $0 copay per visit for annual preventive care exams. • $0 copay per visit for well-woman exams • $0 colonoscopy/sigmoidoscopy • $0 annual screening mammography • $0 copay also includes all items on USPSTF preventive list • Immunizations: No cost for injection only; if part of an office visit, office visit copay will applyection only; if part of an office visit, office visit copay will apply	Not covered
10. **MATERNITY** a) **Prenatal care** b) **Delivery & inpatient well baby care**[5]	a) $25 copay per visit b) $300 copay per admission	Not covered
11. **PRESCRIPTION DRUGS**[6] **Level of coverage and restrictions on prescriptions**	If prescription filled at a Denver Health Pharmacy (30-day supply): Discount: $4 copay Tier 1: $10 copay Tier 2: $15 copay for brand name drugs Tier 3: $30 copay for non-formulary drugs Denver Health Pharmacies or Pharmacy Delivery by Mail (90-day supply): Discount: $8 copay Tier 1: $20 copay Tier 2: $30 copay for brand name drugs Tier 3: $60 copay for non-formulary drugs If prescription filled at a non-Denver Health Pharmacy (30-day supply): Discount: $8 copay Tier 1: $20 copay Tier 2: $30 copay for brand name drugs Tier 3: $60 copay for non-formulary drugs (PA) 30-day supply): Discount: $16 copay Tier 1: $40 copay Tier 2: $60 copay for brand name drugs Tier 3: $120 copay for non-formulary drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
12. **INPATIENT HOSPITAL**	$500 copay per admission Pre-authorization required	Not covered

	In Network	Out-of-Network
13. OUTPATIENT/ AMBULATORY SURGERY	$200 copay Pre-authorization required	Not covered
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI and PET scans**	 a) 100% covered b) $200 copay	Not covered
14A. OTHER DIAGNOSTIC AND THERAPEUTIC SERVICES **a) Sleep study** **b) Radiation therapy** **c) Infusion therapy (Includes chemotherapy)** **d) Injections** **e) Renal dialysis**	 a) $400 copay per visit b) $10 copay per visit c) $10 copay per visit d) $20 copay per visit (excluding immunizations, allergy shots and any other injection given by a nurse) e) Covered at 100%	Not covered
15. EMERGENCY CARE[7, 8]	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)
15A. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
16. AMBULANCE	$450 copay per trip (not waived if admitted)	$450 copay per trip (not waived if admitted)
17. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$50 copay per visit	$50 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit	Not covered
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	 a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit Virtual Residency Therapy is considered outpatient care and the outpatient copay applies for each day of service	Not covered
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 above as a mental disorder)	a) Detoxification: $500 copay per admission . Pre-authorization required. b) Inpatient: $500 copay per admission . Pre-authorization required. c) Outpatient: $40 copay per visit	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$50 copay per visit . Maximum benefit is 20 visits per calendar year per type of therapy.	Not covered

	In Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	Plan pays 70%; maximum benefit is $2,000 per calendar year, pre-authorization required.	Not covered
22A. HEARING AIDS	Medically necessary hearing aids prescribed by a DHMP Medical Care Network Provider are covered every five years in network. For adults age 18 and over, there is a $1,000 benefit maximum every 5 years. Charges exceeding the $1000 hearing aid maximum benefit, are the responsibility of the member. Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under office visits and the applicable copayment applies. Hearing aids do not apply to the annual DME limit.	Not covered
22B. PROSTHETICS	Plan pays 70%. No maximum benefit, does not apply to annual DME limit.	Not covered
22C. ORTHOTICS	Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but must pay out-of-pocket for the orthotic and submit the receipt for reimbursement from DHMP.	
23. OXYGEN	100% covered; Equipment: 30% coinsurance, does not apply to DME maximum.	Not covered
24. ORGAN TRANSPLANTS	$1,000 copay per admission/individual. Only covered at authorized facilities. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants. Pre-authorization required.	Not covered
25. HOME HEALTH CARE	100% covered. Pre-authorization required.	Not covered
26. HOSPICE CARE	100% covered. Pre-authorization required.	Not covered
27. SKILLED NURSING FACILITY CARE	100% covered. Maximum benefit is 100 days per calendar year at authorized facility. Pre-authorization required.	Not covered
28. DENTAL CARE	Not covered except for fluoride varnish at PCP visit for children.	Not covered

	In Network	Out-of-Network
29. VISION CARE	Routine visual screening examinations are not covered. Other ophthalmology services are covered as referred by your PCP and provided by a network provider.	Not covered
30. CHIROPRACTIC CARE	$20 copay per visit. Maximum benefit is 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Autism Services: Expanded services will be available with cost sharing based on type of service. Cochlear implants are now covered for children under age 18. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply. Oral contraceptives are $0 copay both in and out of Denver Health. FDA-approved birth control devices $0 cost sharing. • **Curves Wellness program.** DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least 8 times per month • **Snap Fitness discount** • **Weight Watchers Discount.** DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • **Jenny Craig discount:** members receive a discount on enrollment and 25% off monthly program costs. • **eLearning module for parents-to-be.** Online childbirth classes, free of charge to members • NEW! Take Control of Your Health incentive plan	Not covered

PART C: LIMITATIONS AND EXCLUSIONS

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

PART D: USING THE PLAN

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

Endnotes

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

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

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

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

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

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

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

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

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

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

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

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. "Mental disorders" are defined as post traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa and anorexia nervosa.

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

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

If you have a life or limb-threatening emergency, call 911 or go to the closest hospital emergency department or nearest medical facility.

DHMP, Inc. has an access plan which will be made available to members at their request by calling Member Services at 303-602-2100.

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

Durable Medical Equipment, home health care, including IV therapy, hospital admissions, including substance abuse-related admissions, outpatient surgery, prescription drugs that require pre-authorization as listed in the DHMP formulary (DHMP formulary can be found on our website at www.denverhealthmedicalplan.com), skilled nursing facility admissions, transplant evaluations and procedures, and hospice care. Contact your Primary Care Physician or Specialist to request these services.

12-0725

2013 Colorado Health Benefit Plan Description Form
Denver Health Medical Plan, Inc.
Denver Health Medical Care
Police Protective Association

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

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

	In Network	Out-of- Network
4. DEDUCTIBLE TYPE[2]	Calendar year	N/A
4A. DEDUCTIBLE[2a] **a) [Individual] [Single][2b]** **b) [Family] [Non-single][2c]**	a) $500 per year b) $1,500 per year • Member Copayments do not accumulate towards the Deductible. • All individual Deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual Deductible amount. • This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence deductible must be met prior to and in addition to the Annual Deductible.	N/A
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $2,500 per year b) $5,000 per year c) Yes • The Out-of-Pocket Maximum includes the Annual Deductible. • All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount. • Member Copayments and Per Occurrence Deductibles do not accumulate towards the Out-of-Pocket Maximum.	N/A
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	N/A
7A. COVERED PROVIDERS	Denver Health and Hospital Authority providers, Columbine Chiropractic, and Denver Health Medical Center. See provider directory for a complete list of current providers.	Not covered
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes.	Not applicable

	In Network	Out-of-Network
8. MEDICAL OFFICE VISITS/ SERVICES[4] a) Primary Care Providers b) Specialists	a. $25 Copayment per visit for Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. b. $50 Copayment per visit for Physician Office Visit (with a referral from Primary Physician). In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.	Not covered
9. PREVENTIVE CARE SERVICES a) Children b) Adults	a) No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). b) No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). Lab, X-Ray or other preventive tests No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). $0 copay also includes all items on USPSTF preventive list Immunizations: No cost for injection only; if part of an office visit, office visit copay will apply to injection only; if part of an office visit, office visit copay will apply	Not covered
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care[5]	c. $25 Copayment per visit for In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. a) 20% coinsurance after Per Occurrence Deductible of $150 and Annual Deductible	Not covered

	In Network	Out-of-Network
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	If prescription filled at a Denver Health Pharmacy (30-day supply): Tier 1: $12 copay Tier 2: $40 copay for brand name drugs Tier 3: $50 copay for non-formulary drugs Denver Health Pharmacies or Pharmacy Delivery by Mail (90-day supply): Tier 1: $24 copay Tier 2: $80 copay for brand name drugs Tier 3: $100 copay for non-formulary drugs (PA) If prescription filled at a non-Denver Health Pharmacy (30-day supply): Tier 1: $20 copay Tier 2: $50 copay for brand name drugs Tier 3: $80 copay for non-formulary drugs (PA) If prescription filled at a non-Denver Health Pharmacy (30-day supply): Tier 1: $40 copay Tier 2: $100 copay for brand name drugs Tier 3: $160 copay for non-formulary drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
12. INPATIENT HOSPITAL	20% after: Per Occurrence Deductible of $150 and Annual Deductible have been met (with a referral from your Primary Physician).	
12A. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES	20% after Deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% after Deductible has been met (with a referral from your Primary Physician).	Not covered
12B. CONGENITAL HEART DISEASE (CHD) SURGERIES	20% after Deductible has been met (with a referral from your Primary Physician).	Not covered
13. OUTPATIENT/AMBULATORY SURGERY	20% after: Per Occurrence Deductible of $75 and Annual Deductible have been met (with a referral from your Primary Physician).	
13A. SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC	20% after Deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% after Deductible has been met (with a referral from your Primary Physician). Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, or Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Category.	
13B. RECONSTRUCTIVE PROCEDURES	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services.	a) 20% after Deductible has been met. b) $150 Copayment per service.	

	In Network	Out-of-Network
15. EMERGENCY CARE[7, 8]	$300 Copayment per visit.	$150 copay per visit (waived if admitted)
15A. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
16. AMBULANCE	Ground Transportation: 20% after Deductible has been met. Air Transportation: 20% after Deductible has been met.	$450 copay per trip (not waived if admitted)
17. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$75 Copayment per visit. > In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.	$100 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	a) 20% after Deductible has been met. b) $50 Copayment per visit.	
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 above as a mental disorder)	Inpatient care: 20% after Deductible has been met. Outpatient care: $50 Copayment per visit.	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$25 Copayment per visit. Benefits are subject to combined limits as follows: Physical Therapy - 20 visits per calendar year. Occupational Therapy - 20 visits per calendar year. Speech Therapy - 20 visits per calendar year.	Not covered
21A. CARDIAC & PULMONARY REHABILITATION, & POST-COCHLEAR IMPLANT AURAL THERAPY	$25 Copayment per visit. Benefits are subject to combined limits as follows: Cardiac Rehabilitation - 36 visits per calendar year. Pulmonary Rehabilitation - 20 visits per calendar year. Post-Cochlear Implant Aural Therapy - 30 visits per calendar year. Cognitive Rehabilitation therapy - 20 visits per calendar year.	
21B. REHABILITATION SERVICES – OUTPATIENT THERAPY (CONGENITAL DEFECTS AND BIRTH ABNORMALITIES)	$25 Copayment per visit. Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	
21C. THERAPEUTIC TREATMENTS - OUTPATIENT	20% after Deductible has been met. Therapeutic treatments include, but are not limited to: Dialysis, intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.	
21D. CLINICAL TRIALS	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary	

	In Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	20% after Deductible has been met. Benefits are limited to $2,500 per calendar year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	Not covered
22A. DIABETES SERVICES	Diabetes Self Management and Training. Diabetic Eye Examinations / Foot Care Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Diabetes Self Management Items	
22B. OSTOMY SUPPLIES	20% after Deductible has been met. Benefits for Ostomy Supplies are limited to $2,500 per calendar year.	
22C. PROSTHETIC DEVICES	20% after Deductible has been met. Benefits for Prosthetic Devices are limited to $2,500 per calendar year. This limit does not apply to prosthetic arms, legs, feet and hands. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	
22D. HEARING AIDS FOR ADULTS	20% after Deductible has been met. Benefits for Hearing Aids are limited to $2,500 per calendar year.Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	
23. OXYGEN	Included under Durable Medical Equipment.	
24. ORGAN TRANSPLANTS Depending upon where the Covered Health Service is provided,	Benefits will be the same as those stated under each Covered Health Services category in this Benefit Summary. For In-Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants	
25. HOME HEALTH CARE	20% after Deductible has been met. Benefits are limited to 60 visits for skilled care services per calendar year.	
26. HOSPICE CARE	20% after Deductible has been met. Bereavement support services are limited to a maximum of $1,400 during the 12-month period following the Covered Person's death.	
27. SKILLED NURSING FACILITY CARE	20% after Deductible has been met. Benefits are limited to 60 days per calendar year.	
28. DENTAL CARE	ACCIDENTAL ONLY 20% after Deductible has been met. Benefits are limited as follows: $3,000 maximum per calendar year. $900 maximum per tooth.	

	In Network	Out-of-Network
29. VISION CARE	$25 Copayment per visit. Benefits are limited to 1 exam every 2 calendar years.	Not covered
30. CHIROPRACTIC CARE	$50 Copayment per visit for Manipulative Treatment (provided with a referral from your Primary Physician). Benefits are limited to 20 visits per calendar year.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES 1) CHILDREN'S DENTAL ANESTHESIA 2) CLEFT LIP AND CLEFT PALATE 3) TELEMEDICINE 4) PHENYLKETONURIA (PKU) TESTING AND TREATMENT 5) HEARING AIDS (MINOR CHILDREN)	1) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 2) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 3) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 4) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 5) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. • **Curves Wellness program.** DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least 8 times per month • **Snap Fitness discount** • **Weight Watchers Discount.** DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • **Jenny Craig discount:** members receive a discount on enrollment and 25% off monthly program costs. • **eLearning module for parents-to-be.** Online childbirth classes, free of charge to members • NEW! Take Control of Your Health incentive plan	Not covered

PART C: LIMITATIONS AND EXCLUSIONS

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

PART D: USING THE PLAN

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

Endnotes

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

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

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

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

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

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

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

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

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

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

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

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. "Mental disorders" are defined as post traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa and anorexia nervosa.

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

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

If you have a life or limb-threatening emergency, call 911 or go to the closest hospital emergency department or nearest medical facility.

DHMP, Inc. has an access plan which will be made available to members at their request by calling Member Services at 303-602-2100.

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

Durable Medical Equipment, home health care, including IV therapy, hospital admissions, including substance abuse-related admissions, outpatient surgery, prescription drugs that require pre-authorization as listed in the DHMP formulary (DHMP formulary can be found on our website at www.denverhealthmedicalplan.com), skilled nursing facility admissions, transplant evaluations and procedures, and hospice care. Contact your Primary Care Physician or Specialist to request these services.

12-0725

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

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

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

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

	In Network	Out-of-Network
9. PREVENTIVE CARE SERVICES a) **Children** b) **Adults**	a) $0 copay per visit for well-child exams b) $0 copay per visit for annual preventive care exams. • $0 copay per visit for well-woman exams • $0 colonoscopy/sigmoidoscopy • $0 annual screening mammography • $0 copay also includes all items on USPSTF preventive list • Immunizations: No cost for injection only; if part of an office visit, office visit copay will applyection only; if part of an office visit, office visit copay will apply	Not covered
10. MATERNITY a) **Prenatal care** b) **Delivery & inpatient well baby care**[5]	a) $25 copay per visit b) $300 copay per admission	Not covered
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions**	If prescription filled at a Denver Health Pharmacy (30-day supply): Discount: $4 copay Tier 1: $10 copay Tier 2: $15 copay for brand name drugs Tier 3: $30 copay for non-formulary drugs Denver Health Pharmacies or Pharmacy Delivery by Mail (90-day supply): Discount: $8 copay Tier 1: $20 copay Tier 2: $30 copay for brand name drugs Tier 3: $60 copay for non-formulary drugs If prescription filled at a non-Denver Health Pharmacy (30-day supply): Discount: $8 copay Tier 1: $20 copay Tier 2: $30 copay for brand name drugs Tier 3: $60 copay for non-formulary drugs (PA) 30-day supply): Discount: $16 copay Tier 1: $40 copay Tier 2: $60 copay for brand name drugs Tier 3: $120 copay for non-formulary drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
12. INPATIENT HOSPITAL	$500 copay per admission Pre-authorization required	Not covered

	In Network	Out-of-Network
13. OUTPATIENT/ AMBULATORY SURGERY	$200 copay Pre-authorization required	Not covered
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI and PET scans	 a) 100% covered b) $200 copay	Not covered
14A. OTHER DIAGNOSTIC AND THERAPEUTIC SERVICES a) Sleep study b) Radiation therapy c) Infusion therapy (Includes chemotherapy) d) Injections e) Renal dialysis	 a) $400 copay per visit b) $10 copay per visit c) $10 copay per visit d) $20 copay per visit (excluding immunizations, allergy shots and any other injection given by a nurse) e) Covered at 100%	Not covered
15. EMERGENCY CARE[7, 8]	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)
15A. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
16. AMBULANCE	$450 copay per trip (not waived if admitted)	$450 copay per trip (not waived if admitted)
17. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$50 copay per visit	$50 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit	Not covered
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	 a) Inpatient: $500 copay per admission. Pre-authorization required. b) Outpatient: $40 copay per visit Virtual Residency Therapy is considered outpatient care and the outpatient copay applies for each day of service	Not covered
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 above as a mental disorder)	a) Detoxification: $500 copay per admission . Pre-authorization required. b) Inpatient: $500 copay per admission . Pre-authorization required. c) Outpatient: $40 copay per visit	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$50 copay per visit . Maximum benefit is 20 visits per calendar year per type of therapy.	Not covered

	In Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	Plan pays 70%; maximum benefit is $2,000 per calendar year, pre-authorization required.	Not covered
22A. HEARING AIDS	Medically necessary hearing aids prescribed by a DHMP Medical Care Network Provider are covered every five years in network. For adults age 18 and over, there is a $1,000 benefit maximum every 5 years. Charges exceeding the $1000 hearing aid maximum benefit, are the responsibility of the member. Children under age 18 are covered at 100%, no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under office visits and the applicable copayment applies. Hearing aids do not apply to the annual DME limit.	Not covered
22B. PROSTHETICS	Plan pays 70%. No maximum benefit, does not apply to annual DME limit.	Not covered
22C. ORTHOTICS	Custom shoe orthotics are covered up to $50 per calendar year. You may obtain the orthotic from any vendor but must pay out-of-pocket for the orthotic and submit the receipt for reimbursement from DHMP.	
23. OXYGEN	100% covered; Equipment: 30% coinsurance, does not apply to DME maximum.	Not covered
24. ORGAN TRANSPLANTS	$1,000 copay per admission/individual. Only covered at authorized facilities. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants. Pre-authorization required.	Not covered
25. HOME HEALTH CARE	100% covered. Pre-authorization required.	Not covered
26. HOSPICE CARE	100% covered. Pre-authorization required.	Not covered
27. SKILLED NURSING FACILITY CARE	100% covered. Maximum benefit is 100 days per calendar year at authorized facility. Pre-authorization required.	Not covered
28. DENTAL CARE	Not covered except for fluoride varnish at PCP visit for children.	Not covered

	In Network	Out-of-Network
29. VISION CARE	Routine visual screening examinations are not covered. Other ophthalmology services are covered as referred by your PCP and provided by a network provider.	Not covered
30. CHIROPRACTIC CARE	$20 copay per visit. Maximum benefit is 20 visits per calendar year. Services must be provided by Columbine Chiropractic in order to be covered.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Autism Services: Expanded services will be available with cost sharing based on type of service. Cochlear implants are now covered for children under age 18. The device is covered at 100%, applicable inpatient/outpatient surgery charges will apply. Oral contraceptives are $0 copay both in and out of Denver Health. FDA-approved birth control devices $0 cost sharing. • **Curves Wellness program.** DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least 8 times per month • **Snap Fitness discount** • **Weight Watchers Discount.** DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • **Jenny Craig discount:** members receive a discount on enrollment and 25% off monthly program costs. • **eLearning module for parents-to-be.** Online childbirth classes, free of charge to members • NEW! Take Control of Your Health incentive plan	Not covered

PART C: LIMITATIONS AND EXCLUSIONS

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

PART D: USING THE PLAN

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

Endnotes

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

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

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

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

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

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

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

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

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

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

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

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. "Mental disorders" are defined as post traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa and anorexia nervosa.

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

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

If you have a life or limb-threatening emergency, call 911 or go to the closest hospital emergency department or nearest medical facility.

DHMP, Inc. has an access plan which will be made available to members at their request by calling Member Services at 303-602-2100.

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

Durable Medical Equipment, home health care, including IV therapy, hospital admissions, including substance abuse-related admissions, outpatient surgery, prescription drugs that require pre-authorization as listed in the DHMP formulary (DHMP formulary can be found on our website at www.denverhealthmedicalplan.com), skilled nursing facility admissions, transplant evaluations and procedures, and hospice care. Contact your Primary Care Physician or Specialist to request these services.

12-0725

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

PART A: TYPE OF COVERAGE

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

PART B: SUMMARY OF BENEFITS

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

	In Network	Out-of- Network
4. DEDUCTIBLE TYPE[2]	Calendar year	N/A
4A. DEDUCTIBLE[2a] **a) [Individual] [Single][2b]** **b) [Family] [Non-single][2c]**	a) $500 per year b) $1,500 per year • Member Copayments do not accumulate towards the Deductible. • All individual Deductible amounts will count toward the family deductible, but an individual will not have to pay more than the individual Deductible amount. • This benefit plan contains a Per Occurrence Deductible that applies to certain Covered Health Services. This Per Occurrence deductible must be met prior to and in addition to the Annual Deductible.	N/A
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	a) $2,500 per year b) $5,000 per year c) Yes • The Out-of-Pocket Maximum includes the Annual Deductible. • All individual Out-of-Pocket Maximum amounts will count toward the family Out-of-Pocket Maximum, but an individual will not have to pay more than the individual Out-of-Pocket Maximum amount. • Member Copayments and Per Occurrence Deductibles do not accumulate towards the Out-of-Pocket Maximum.	N/A
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum	N/A
7A. COVERED PROVIDERS	Denver Health and Hospital Authority providers, Columbine Chiropractic, and Denver Health Medical Center. See provider directory for a complete list of current providers.	Not covered
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes.	Not applicable

	In Network	Out-of-Network
8. MEDICAL OFFICE VISITS/ SERVICES[4] a) Primary Care Providers b) Specialists	a. $25 Copayment per visit for Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. b. $50 Copayment per visit for Physician Office Visit (with a referral from Primary Physician). In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.	Not covered
9. PREVENTIVE CARE SERVICES a) Children b) Adults	a) No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). b) No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). Lab, X-Ray or other preventive tests No copayment (100% covered): Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. Physician Office Visit (with a referral from Primary Physician). $0 copay also includes all items on USPSTF preventive list Immunizations: No cost for injection only; if part of an office visit, office visit copay will apply to injection only; if part of an office visit, office visit copay will apply	Not covered
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care[5]	c. $25 Copayment per visit for In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. a) 20% coinsurance after Per Occurrence Deductible of $150 and Annual Deductible	Not covered

	In Network	Out-of-Network
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions	If prescription filled at a Denver Health Pharmacy (30-day supply): Tier 1: $12 copay Tier 2: $40 copay for brand name drugs Tier 3: $50 copay for non-formulary drugs Denver Health Pharmacies or Pharmacy Delivery by Mail (90-day supply): Tier 1: $24 copay Tier 2: $80 copay for brand name drugs Tier 3: $100 copay for non-formulary drugs (PA) If prescription filled at a non-Denver Health Pharmacy (30-day supply): Tier 1: $20 copay Tier 2: $50 copay for brand name drugs Tier 3: $80 copay for non-formulary drugs (PA) If prescription filled at a non-Denver Health Pharmacy (30-day supply): Tier 1: $40 copay Tier 2: $100 copay for brand name drugs Tier 3: $160 copay for non-formulary drugs (PA) For drugs on our approved list, contact Member Services at 303-602-2100	Not covered
12. INPATIENT HOSPITAL	20% after: Per Occurrence Deductible of $150 and Annual Deductible have been met (with a referral from your Primary Physician).	
12A. PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES	20% after Deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% after Deductible has been met (with a referral from your Primary Physician).	Not covered
12B. CONGENITAL HEART DISEASE (CHD) SURGERIES	20% after Deductible has been met (with a referral from your Primary Physician).	Not covered
13. OUTPATIENT/AMBULATORY SURGERY	20% after: Per Occurrence Deductible of $75 and Annual Deductible have been met (with a referral from your Primary Physician).	
13A. SCOPIC PROCEDURES - OUTPATIENT DIAGNOSTIC AND THERAPEUTIC	20% after Deductible has been met for services provided by your Primary Physician or In-Network obstetrician, gynecologist or advanced practice nurse who is a certified midwife. 20% after Deductible has been met (with a referral from your Primary Physician). Diagnostic scopic procedures include, but are not limited to: Colonoscopy, Sigmoidoscopy, or Endoscopy. For Preventive Scopic Procedures, refer to the Preventive Care Category.	
13B. RECONSTRUCTIVE PROCEDURES	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary.	
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services.	a) 20% after Deductible has been met. b) $150 Copayment per service.	

	In Network	Out-of-Network
15. EMERGENCY CARE[7,8]	$300 Copayment per visit.	$150 copay per visit (waived if admitted)
15A. OBSERVATION STAYS	$150 copay (waived if admitted)	$150 copay (waived if admitted)
16. AMBULANCE	Ground Transportation: 20% after Deductible has been met. Air Transportation: 20% after Deductible has been met.	$450 copay per trip (not waived if admitted)
17. URGENT, NON-ROUTINE SERVICES, AFTER HOURS CARE	$75 Copayment per visit. > In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: CT, PET, MRI, MRA, Nuclear Medicine; Pharmaceutical Products, Scopic Procedures; Surgery; Therapeutic Treatments.	$100 copay per visit
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE AND MENTAL DISORDERS[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	 a) 20% after Deductible has been met. b) $50 Copayment per visit.	
20. ALCOHOL & SUBSTANCE ABUSE (If not covered under #18 above as a mental disorder)	Inpatient care: 20% after Deductible has been met. Outpatient care: $50 Copayment per visit.	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	$25 Copayment per visit. Benefits are subject to combined limits as follows: Physical Therapy - 20 visits per calendar year. Occupational Therapy - 20 visits per calendar year. Speech Therapy - 20 visits per calendar year.	Not covered
21A. CARDIAC & PULMONARY REHABILITATION, & POST-COCHLEAR IMPLANT AURAL THERAPY	$25 Copayment per visit. Benefits are subject to combined limits as follows: Cardiac Rehabilitation - 36 visits per calendar year. Pulmonary Rehabilitation - 20 visits per calendar year. Post-Cochlear Implant Aural Therapy - 30 visits per calendar year. Cognitive Rehabilitation therapy - 20 visits per calendar year.	
21B. REHABILITATION SERVICES – OUTPATIENT THERAPY (CONGENITAL DEFECTS AND BIRTH ABNORMALITIES)	$25 Copayment per visit. Care and treatment of congenital defect and birth abnormalities for children from age 3 to age 6 are covered 20 visits each for physical, occupational and speech therapy, without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	
21C. THERAPEUTIC TREATMENTS - OUTPATIENT	20% after Deductible has been met. Therapeutic treatments include, but are not limited to: Dialysis, intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.	
21D. CLINICAL TRIALS	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary	

	In Network	Out-of-Network
22. DURABLE MEDICAL EQUIPMENT	20% after Deductible has been met. Benefits are limited to $2,500 per calendar year and are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. This limit does not apply to wound vacuums. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	Not covered
22A. DIABETES SERVICES	Diabetes Self Management and Training. Diabetic Eye Examinations / Foot Care Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. Diabetes Self Management Items	
22B. OSTOMY SUPPLIES	20% after Deductible has been met. Benefits for Ostomy Supplies are limited to $2,500 per calendar year.	
22C. PROSTHETIC DEVICES	20% after Deductible has been met. Benefits for Prosthetic Devices are limited to $2,500 per calendar year. This limit does not apply to prosthetic arms, legs, feet and hands. This benefit category contains services/ devices that may be Essential or non-Essential Health Benefits as defined by the Patient Protection and Affordable Care Act depending upon the service or device delivered. A benefit review will take place once the dollar limit is exceeded. If the service/device is determined to be rehabilitative or habilitative in nature, it is an Essential Health Benefit and will be paid. If the benefit/device is determined to be non-essential, the maximum will have been met and the claim will not be paid.	
22D. HEARING AIDS FOR ADULTS	20% after Deductible has been met. Benefits for Hearing Aids are limited to $2,500 per calendar year.Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	
23. OXYGEN	Included under Durable Medical Equipment.	
24. ORGAN TRANSPLANTS Depending upon where the Covered Health Service is provided,	Benefits will be the same as those stated under each Covered Health Services category in this Benefit Summary. For In-Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants	
25. HOME HEALTH CARE	20% after Deductible has been met. Benefits are limited to 60 visits for skilled care services per calendar year.	
26. HOSPICE CARE	20% after Deductible has been met. Bereavement support services are limited to a maximum of $1,400 during the 12-month period following the Covered Person's death.	
27. SKILLED NURSING FACILITY CARE	20% after Deductible has been met. Benefits are limited to 60 days per calendar year.	
28. DENTAL CARE	ACCIDENTAL ONLY 20% after Deductible has been met. Benefits are limited as follows: $3,000 maximum per calendar year. $900 maximum per tooth.	

	In Network	Out-of-Network
29. VISION CARE	$25 Copayment per visit. Benefits are limited to 1 exam every 2 calendar years.	Not covered
30. CHIROPRACTIC CARE	$50 Copayment per visit for Manipulative Treatment (provided with a referral from your Primary Physician). Benefits are limited to 20 visits per calendar year.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES 1) CHILDREN'S DENTAL ANESTHESIA 2) CLEFT LIP AND CLEFT PALATE 3) TELEMEDICINE 4) PHENYLKETONURIA (PKU) TESTING AND TREATMENT 5) HEARING AIDS (MINOR CHILDREN)	1) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 2) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 3) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 4) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. 5) Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary. • **Curves Wellness program.** DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least 8 times per month • **Snap Fitness discount** • **Weight Watchers Discount.** DHMP will share the cost of Weight Watchers with members. Join Weight Watchers through DHMP and the plan will pay 35% of your cost! • **Jenny Craig discount:** members receive a discount on enrollment and 25% off monthly program costs. • **eLearning module for parents-to-be.** Online childbirth classes, free of charge to members • NEW! Take Control of Your Health incentive plan	Not covered

PART C: LIMITATIONS AND EXCLUSIONS

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

PART D: USING THE PLAN

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

Endnotes

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

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

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

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

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

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

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

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

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

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

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

9 "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. "Mental disorders" are defined as post traumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, bulimia nervosa and anorexia nervosa.

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

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

If you have a life or limb-threatening emergency, call 911 or go to the closest hospital emergency department or nearest medical facility.

DHMP, Inc. has an access plan which will be made available to members at their request by calling Member Services at 303-602-2100.

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

Durable Medical Equipment, home health care, including IV therapy, hospital admissions, including substance abuse-related admissions, outpatient surgery, prescription drugs that require pre-authorization as listed in the DHMP formulary (DHMP formulary can be found on our website at www.denverhealthmedicalplan.com), skilled nursing facility admissions, transplant evaluations and procedures, and hospice care. Contact your Primary Care Physician or Specialist to request these services.