2016
Denver Public Schools
DHMP
$1300 CDHP

HighPoint Denver ***Plus*** Network

	HighPoint Denver	Cofinity Network	Out of Network
Deductible			
Individual Family	■ $1,300 per plan year. ■ $2,600 per plan year. Applicable to medical care & prescription drug benefits; family deductible includes employee & one or more enrolled family members, no coverage may be paid for any family member unless the family deductible is met. Services received in either tier will accumulate towards this amount.		Not applicable.
Out of Pocket Maximum			
Individual Family	■ $2,600 per plan year. ■ $5,200 per plan year. **The out-of-pocket maximum includes the annual deductible, coinsurance and pharmacy copays. It does not include premiums**. Applicable to medical care & prescription drug benefits; family out-of-pocket maximum includes employee & one or more enrolled family members, maximum is not met for any family member unless the family out-of-pocket maximum is met. Services received in either tier will accumulate towards this amount.		Not applicable.
Lifetime Maximum			
	■ No lifetime maximum.	■ No lifetime maximum.	Not applicable.
Covered Providers			
	■ Denver Health and Hospital Authority, University of Colorado Hospital and Children's Hospital Colorado providers and facilities including Colorado Health Medical Group (CHMG) and Colorado Pediatric Partners (CPP). Columbine network for chiropractic. See online provider directory for a complete list of current providers: visit www.DHMP.online and click on *Find a Doctor*, or call us at 303-602-4DPS (4377).	■ Cofinity network providers and facilities. Columbine network for chiropractic. See online provider directory for a complete list of current providers: visit www.DHMP.online and click on *Find a Doctor*, or go to www.cofinity.net. You may also call Member Services at 303-602-4DPS (4377).	Not applicable.
Medical Office Visits			
Personal providers (Family Medicine, Internal Medicine and Pediatrics)	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	Not covered.
Specialist	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	Not covered.

* Prior authorization required

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, cost share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the Evidence of Coverage found at www.DHMP.online.

	HighPoint Denver	Cofinity Network	Out of Network
Preventive Services			
Children Adults	■ 100% covered. This applies to all preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF). Annual well visit, well woman exams, prenatal visits; colonoscopy, mammogram. See USPSTF list on our website at www.DHMP.online	■ 100% covered. This applies to all preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (USPSTF). Annual well visit, well woman exams, prenatal visits; colonoscopy, mammogram. See USPSTF list on our website at www.DHMP.online	Not covered.
Maternity			
Prenatal Care Delivery, Inpatient and Well Baby Care	■ Prenatal visits are preventive and are covered at 100%. ■ Deductible and 10% coinsurance will apply.	■ Prenatal visits are preventive and are covered at 100%. ■ Deductible and 20% coinsurance will apply.	Not covered.
Prescription Drugs			
	■ Preventive pharmacy covered at 100%. ■ Deductible will apply. **After deductible is met:** Denver Health Pharmacy* (30-day supply) ■ Preferred Generics: $10 copay ■ Generics & Preferred Brand: $15 copay ■ Non-preferred Brand: $30 copay ■ Specialty: $30 copay Denver Health Pharmacy or Denver Health Retail by Mail* (90-day supply) ■ Preferred Generics: $20 copay ■ Generics & Preferred Brand: $30 copay ■ Non-preferred Brand: $60 copay ■ Specialty: N/A MedImpact Network Pharmacy** (30-day supply) ■ Preferred Generics: $20 copay ■ Generics & Preferred Brand: $40 copay ■ Non-preferred Brand: $60 copay ■ Specialty: $60 copay MedImpact Network Pharmacy** or MedVantx Mail Order (90-day supply) ■ Preferred Generics: $40 copay ■ Generics & Preferred Brand: $80 copay ■ Non-preferred Brand: $120 copay ■ Specialty: N/A	■ Preventive pharmacy covered at 100%. ■ Deductible will apply. **After deductible is met:** MedImpact Network Pharmacy** (30-day supply) ■ Preferred Generics: $20 copay ■ Generics & Preferred Brand: $40 copay ■ Non-preferred Brand: $60 copay ■ Specialty: $60 copay MedImpact Network Pharmacy** or MedVantx Mail Order (90-day supply) ■ Preferred Generics: $40 copay ■ Generics & Preferred Brand: $80 copay ■ Non-preferred Brand: $120 copay ■ Specialty: N/A	Not covered.
	For drugs on our approved list, call Member Services at 303-602-4DPS (4377), or visit www.DHMP.online. *Prescriptions filled at Denver Health pharmacies must be written by a Denver Health physician. **MedImpact Network Pharmacies generally include most retail pharmacies such as Target, King Soopers, Safeway, etc.		

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Inpatient Hospital			
	■ Deductible and 10% coinsurance will apply.* Maximum on surgical treatment of morbid obesity of once per lifetime.	■ Deductible and 20% coinsurance will apply.* Maximum on surgical treatment of morbid obesity of once per lifetime.	Not covered.
Outpatient/Ambulatory Surgery			
	■ Deductible and 10% coinsurance will apply.*	■ Deductible and 20% coinsurance will apply.*	Not covered.
Diagnostics Laboratory and Radiology			
Laboratory, X-ray and CT scans	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	Not covered.
MRI and PET scans	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	
Other Diagnostic and Therapeutic Services			
Sleep study	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	Not covered.
Radiation therapy	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	
Infusion therapy (includes chemotherapy)	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	
Injections	■ Deductible and 10% coinsurance will apply (immunizations, allergy shots and any other injection given by a nurse is $0).	■ Deductible and 20% coinsurance will apply (immunizations, allergy shots and any other injection given by a nurse is $0).	
Renal Dialysis	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	
Emergency Care			
	■ Deductible and 10% coinsurance will apply.	■ Deductible and 10% coinsurance will apply.	Deductible and 10% coinsurance will apply.
Urgent Care			
	■ Deductible and 10% coinsurance will apply.	■ Deductible and 10% coinsurance will apply.	Deductible and 10% coinsurance will apply.
Ambulance			
	■ Deductible and 10% coinsurance will apply.	■ Deductible and 10% coinsurance will apply.	Deductible and 10% coinsurance will apply.
Behavioral Health, Mental Health Care and Substance Abuse			
Outpatient:	■ Deductible and 10% coinsurance will apply.	■ Deductible and 20% coinsurance will apply.	Not covered.
Inpatient:	■ Deductible and 10% coinsurance will apply.*	■ Deductible and 20% coinsurance will apply.*	Not covered.

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Therapies			
Rehabilitative: Physical, Occupational, and Speech Therapy	■ Deductible and 10% coinsurance will apply. ■ 20 of each therapy per plan year.	■ Deductible and 20% coinsurance will apply. ■ 20 of each therapy per plan year.	Not covered.
Habilitative: Physical, Occupational, and Speech Therapy	■ Deductible and 10% coinsurance will apply. ■ 20 of each therapy per plan year.	■ Deductible and 20% coinsurance will apply. ■ 20 of each therapy per plan year.	Not covered.
Pulmonary Rehabilitation	■ Deductible and 10% coinsurance will apply. ■ 20 of each therapy per plan year.	■ Deductible and 20% coinsurance will apply. ■ 20 of each therapy per plan year.	Not covered.
Cardiac Rehabilitation	■ Deductible and 10% coinsurance will apply. ■ 20 of each therapy per plan year.	■ Deductible and 20% coinsurance will apply. ■ 20 of each therapy per plan year.	Not covered.
	Benefit limit per type of therapy is a combined total of visits in both HighPoint and Cofinity.		
Durable Medical Equipment			
	■ Deductible and 10% coinsurance will apply.*	■ Deductible and 20% coinsurance will apply.*	Not covered.
Hearing Aids			
Adults	■ Deductible and 10% coinsurance. Medically-necessary hearing aids prescribed by a DHMP Network provider are covered every five years in network. For adults age over 18, there is a $1,500 benefit maximum every 5 years. After deductible is met, DHMP will pay up to $1,500 benefit maximum. Charges exceeding the $1,500 hearing aid maximum benefit, are the responsibility of the member.	■ Deductible and 20% coinsurance. Medically-necessary hearing aids prescribed by a DHMP Network provider are covered every five years in network. For adults age over 18, there is a $1,500 benefit maximum every 5 years. After deductible is met, DHMP will pay up to $1,500 benefit maximum. Charges exceeding the $1,500 hearing aid maximum benefit, are the responsibility of the member.	Not covered.
Children	■ Deductible and 10% coinsurance. Children under age 18 are covered with no maximum benefit. Hearing screens and fittings for hearing aids are covered under office visits and the applicable cost sharing applies.* ■ Cochlear implants are now covered for children under age 18. The device is covered at 100% after deductible is met, applicable inpatient/outpatient surgery charges will apply.*	■ Deductible and 20% coinsurance. Children under age 18 are covered with no maximum benefit. Hearing screens and fittings for hearing aids are covered under office visits and the applicable cost sharing applies.* ■ Cochlear implants are now covered for children under age 18. The device is covered at 100% after deductible is met, applicable inpatient/outpatient surgery charges will apply.*	
Prosthetics/Orthotics			
	■ Deductible and 10% coinsurance will apply; no maximum benefit.*	■ Deductible and 20% coinsurance will apply; no maximum benefit.*	Not covered.
Orthotics (Shoe)			
	Medically necessary orthotics are reimbursed up to $100 per plan year after deductible is met.		
Oxygen/Oxygen Equipment			
Oxygen	■ 100% covered after deductible is met; no maximum benefit.*	■ 100% covered after deductible is met; no maximum benefit.*	Not covered.
Equipment	■ Deductible and 10% coinsurance will apply; no maximum benefit.*	■ Deductible and 20% coinsurance will apply; no maximum benefit.*	Not covered.

	HighPoint Denver	Cofinity Network	Out of Network
Organ Transplants			
	■ Deductible and 10% coinsurance will apply. Only covered at authorized facilities. Coverage no less extensive than for other physical illness. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants.*	■ Deductible and 20% coinsurance will apply. Only covered at authorized facilities. Coverage no less extensive than for other physical illness. Covered transplants include: cornea, kidney, kidney-pancreas, heart, lung, heart-lung, liver and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer and Wiskott-Aldrich Syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants.*	Not covered.
Home Health Care			
	■ Deductible and 10% coinsurance will apply for prescribed medically necessary skilled home health services.*	■ Deductible and 20% coinsurance will apply for prescribed medically necessary skilled home health services.*	Not covered.
Hospice Care			
	■ Deductible and 10% coinsurance will apply.*	■ Deductible and 20% coinsurance will apply.*	Not covered.
Skilled Nursing Facility			
	■ Deductible and 10% coinsurance will apply. Maximum benefit is 100 days per plan year at authorized facility.*	■ Deductible and 20% coinsurance will apply. Maximum benefit is 100 days per plan year at authorized facility.*	Not covered.
Dental Care			
	■ Not covered except for fluoride varnish at PCP visit. This is preventive and will be 100% covered.		Not covered.
Routine Vision Care			
	Not covered.	Not covered.	Not covered.
Chiropractic			
	■ Deductible and 10% coinsurance will apply. Maximum 20 visits per plan year. Services must be provided by Columbine Chiropractic in order to be covered.		Not covered.
	Note: Acupuncture is not a plan benefit but DHMP offers a discount program through Columbine Chiropractic. Many chiropractic offices offer acupuncture as well. DHMP will not pay for acupuncture received at a Columbine Chiropractic office. Member must pay through discount program.		
Additional Benefits			
	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! **Curves Wellness program.** DHMP will pay $20 toward the monthly fee for every month that members who join Curves work out at least eight times per month. **eLearning** module for parents-to-be. Online childbirth classes, free of charge to members. **STRONG body STRONG mind** incentive plan.		

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