

Example #4 - Well Woman Visit and Pap Smear

Example #5 - Colonoscopy

Office Visit and Pap Smear

Office Visit and Pap Smear

Point of Service Member using the Denver Health Medical Center System

Pathology and office visit: \$5 copay

No laboratory fees apply

Total Out of Pocket: \$5

Point of Service Member using the Preferred Provider Network

Pathology and office visit: \$15 copay

No laboratory fees apply

Total Out of Pocket: \$15

Point of Service Member Going Out-of-Network

Office visit \$175

Lab charges for pap smear \$ 55

Total Out of Pocket: \$230

In this example, member is responsible for deductible and 50% coinsurance up to **Maximum out-of-pocket** dollar amount or \$10,000. Member has not met deductible of \$1,500. Member is responsible for all charges related to office visit.

Point of Service Member using the Denver Health Medical Center System

Colonoscopy charges \$1,275

Member pays: \$0 copay

Total Out of Pocket: \$0

Point of Service Member using the Preferred Provider Network

Colonoscopy charges \$1,275

Member pays: \$100 copay

Total Out of Pocket: \$100

Point of Service Member Going Out-of-Network

Colonoscopy charges \$1,275

Total Out of Pocket: \$1,275

In this example, member is responsible for deductible and 50% coinsurance up to **Maximum out-of-pocket** dollar amount or \$10,000. Member has not met deductible of \$1,500. Member is responsible for all charges related to colonoscopy..

Member Services: (720) 956-2100



2010 Point of Service Plan Guide

Point of Service Plan members have the option of receiving health care in three different ways:

1. **Denver Health Medical Center system**
2. **Preferred Provider Network (Cofinity Network)**
3. **Out-of-Network (Any provider)**

Out-of-pocket costs to the member are greatest when using the Out-of-Network option, where most services require a higher deductible and coinsurance. When a member uses the Preferred Provider Network (Cofinity network) some services simply require a copay while others require deductible and coinsurance. If members use the Denver Health Medical Center system, copays apply; there is never a deductible or coinsurance.

This guide includes definitions and examples to help you understand how the Point of Service Plan works. If you have further questions or concerns, call Member Services at (720) 956-2100.

Health Care Plan Definitions

Authorization Required

Prior approval must be obtained from the health care plan for certain services and products in order for the cost to be paid by the plan.

Copayment

A copayment is that portion of covered expenses that a member is required to pay out of their pocket in addition to the amount the Plan will pay for the services received. copayments do not apply to the out-of-pocket maximum or the deductible.

Coinsurance

A provision by which the insured individual shares in the cost of certain expenses. Coinsurance percentage reflects the amount the MEMBER will pay.

Deductible

A deductible is a specified amount of expense for a covered service that you must pay within the calendar year before the Plan provides benefits.

Explanation of Benefits

This document is sent to the Point of Service member when a non-pharmacy claim is submitted.

In-network

Health care providers, hospitals, etc., participating within Denver Health Medical Plan, Inc., i.e., Denver Health Medical Center and Cofinity network.

Out-of-network

Health care providers, hospitals, etc., not contracted with Denver Health Medical Plan, Inc. or Cofinity.

Point of Service

An HMO plan with some out-of-network benefits

Preferred Provider Network

The Cofinity network.

Usual and Customary

The usual charge of most providers for the service given the geographic area. Out-of-network claims will be re-priced to the lower of billed charges or usual and customary. If billed charges are higher than usual and customary as determined by the Plan, then the member is responsible for 100% of the difference between billed charges and usual and customary.

2010 Cost Comparison Samples

Listed below is an out-of-pocket comparison of routine costs which may be incurred based on the network of service used. These charges are simply estimates for the sole purpose of illustrating cost differences in each network of service. The charges are not necessarily reflective of actual charges for services.

For the purpose of this guide, all examples assume the member's deductible has NOT been met.

NOTE: Preferred Provider network deductible and Out-of-Network deductible are separate. These deductibles do NOT accumulate together.

Example #1: Delivery of Baby

Point of Service Member using the Denver Health Medical Center System

Copay Delivery/hospitalization: \$200

**Total Out of Pocket:
\$200**

Point of Service Member using the Preferred Provider Network

In this example, the member is responsible for 20% coinsurance up to **Maximum out-of-pocket** dollar amount or \$1,500, including deductible. The 20% coinsurance is \$800 (less than **maximum out-of-pocket** dollar amount). Therefore, the member is responsible for \$800 coinsurance plus \$400 deductible for a total out-of-pocket of \$1,200.

Estimated charges for delivery/hospitalization

(at a Cofinity provider): \$4,400

Mother's Deductible: (\$ 400)

Leaving a balance of: \$4,000

Plan pays 80% of the balance: (\$3,200)

Patient 20% Coinsurance: \$ 800

**Total Out of Pocket:
\$1,200**

Point of Service Member Going Out-of-Network

In this example, the member is responsible for 50% coinsurance up to **Maximum out-of-pocket** dollar amount or \$10,000, including deductible. The 50% coinsurance is \$1,450 (less than **maximum out-of-pocket** dollar amount). Therefore, the member is responsible for \$1,450 coinsurance AND \$1,500 deductible for a total out-of-pocket of \$2,950. **If patient chooses to go out-of-network and their physician charges more than allowable, patient is responsible for the difference between allowable and actual charges.*

Estimated charges for delivery/hospitalization: \$4,400*

Mother's Deductible: (\$1,500)

Leaving a balance of: \$2,900

Plan pays 50% of allowable balance (\$1,450)

Patient 50% Coinsurance: \$1,450

**Total Out of Pocket:
\$2,950**

NOTE: Regardless of the network used, if mother and baby are discharged at the same time only one copay is charged; if mother and baby are discharged at separate times each will have a copay. The same applies for deductible and coinsurance.

Example #2 - Lab Tests

Point of Service Member using the Denver Health Medical Center System

Laboratory tests: \$275

Total Out of Pocket:
\$0

Point of Service Member using the Preferred Provider Network

Laboratory tests: \$275

Patient Deductible:
(**\$275 applies to patient's \$400 deductible**)

Leaving a balance of: \$275
Plan pays 80% of the balance: \$ 0
Patient 20% Coinsurance: \$ 0

Total Out of Pocket:
\$275

In this example, member is responsible for deductible and 20% coinsurance *up to* **maximum out-of-pocket** dollar amount or \$1,500. \$275 is applied to \$400 deductible. The deductible is NOT MET so patient is responsible for 100% of \$275 laboratory charges.

Point of Service Member Going Out-of-Network

Laboratory tests: \$ 275*

Patient Deductible: (\$ 1,500)

Leaving a balance of: \$ 0
Plan pays 50% of the balance: \$ 0

Total Out of Pocket:
\$275

In this example, member is responsible for deductible and 50% coinsurance *up to* **Maximum out-of-pocket** dollar amount or \$10,000. The member has not met deductible of \$1,500. The member is responsible for 100% of \$275 laboratory charges.

**If patient chooses to go out-of-network and their physician charges more than allowable, patient is responsible for the difference between allowable and actual charges.*

Example #3 - Hip Replacement

Point of Service Member using the Denver Health Medical Center System

Hip Replacement Surgery: \$36,000

Total Out of Pocket:
\$300

Point of Service Member using the Preferred Provider Network

Hip Replacement Surgery: \$36,000

Patient Deductible: (\$ 400)

Leaving a balance of: \$35,600
Plan pays 80%: (\$28,480)

Leaving 20% coinsurance of: \$ 7,120

Total Out of Pocket:
\$1,500

In this example, member is responsible for 20% coinsurance *up to* **Maximum out-of-pocket** dollar amount or \$1,500, including deductible. The 20% coinsurance is \$7,120 (which is more than **Maximum out-of-pocket** dollar amount). Therefore, member is responsible only for \$1,100 of this amount plus \$400 deductible for a total out-of-pocket amount of \$1,500.

Point of Service Member Going Out-of-Network

Hip Replacement Surgery: \$36,000*

Patient Deductible: (\$ 1,500)

Leaving a balance of: \$34,500

Plan pays 50% of the allowable balance: (\$17,250)

50% Coinsurance: \$17,250

Total Out of Pocket:
\$10,000

In this example, member is responsible for 50% coinsurance *up to* **Maximum out-of-pocket** dollar amount or \$10,000, including deductible. 50% coinsurance is \$17,250 (which is more than **Maximum out-of-pocket** dollar amount). Therefore, member is responsible only for \$8,500 of this amount plus \$1,500 deductible for a total out-of-pocket amount of \$10,000.