




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-700-8140. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.denverhealthmedicalplan.org or call 1-800-700-8140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 individual or \$1,500 family for In-Network. \$750 individual or \$1,750 family for Cofinity Network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible ?	Yes. Preventive care services and preventive pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes, \$150 per occurrence for delivery and inpatient hospitalization or outpatient/ambulatory surgery.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For in-network providers \$3,000 individual or \$6,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider ?	Yes. See www.denverhealthmedicalplan.org or call 1-800-700-8140 for a list of network providers.	This plan uses a provider network. You will pay the least if you use a provider in the Denver Health network. You pay more if you use a provider in the Cofinity network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. Out-of-network providers are not covered on this plan except for urgent care or emergency.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.

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 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Denver Health Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat An injury or illness	\$25 copay per visit	\$30 copay per visit	Not covered	-----none-----
	Specialist visit	\$50 copay per visit	\$50 copay per visit	Not covered	-----none-----
	Preventive care/screening/immunization	\$0 coinsurance	\$0 coinsurance	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Deductible and 20% Coinsurance	Deductible and 30% coinsurance	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$150 copay per visit*	\$200 copay per visit*	Not covered	* Pre-authorization required for PET scans and MRI only
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.denverhealthmedicalplan.org	Discount drugs/ Generic drugs (Tier 1)/ Non-preferred Generic (Tier 2)	30 day supply: DH Pharmacy \$10 copay (discount); \$12 copay (generic); \$35 copay (non-preferred generic) Mail Order supply: DH Pharmacy \$20 copay (discount); \$24 copay (generic); \$70 copay (non-preferred generic)	30 day supply: National Network Pharmacy \$20 copay (discount); \$24 copay (generic); \$70 copay (non-preferred generic) Mail Order supply: National Network Pharmacy \$40 copay (discount); \$48 copay (generic); \$140 copay (non-preferred generic).	Not covered	Provider means pharmacy for purposes of this section. You may need to obtain certain prescription drugs from a pharmacy designated by us. Certain drugs may have a preauthorization requirement, or may result in a higher cost. Please see our website listed for information on drugs covered at retail or by mail order prescription. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 3)	30 day supply: DH Pharmacy \$45 copay; Mail Order supply: DH Pharmacy \$90 copay.	30 day supply: National Network Pharmacy \$90 copay. Mail Order supply: National Network Pharmacy \$180 copay.	Not covered	

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	Non-preferred brand drugs (Tier 4)	30 day supply: DH Pharmacy \$55 copay; Mail Order supply: DH Pharmacy \$110 copay.	30 day supply: National Network Pharmacy \$110 copay. Mail Order supply: National Network Pharmacy \$220 copay.	Not covered	Provider means pharmacy for purposes of this section. You may need to obtain certain prescription drugs from a pharmacy designated by us. Certain drugs may have a preauthorization requirement, or result in a higher cost. Please see our website listed for information on drugs covered. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Specialty drugs (Tier 5)	30 day supply: DH Pharmacy \$65 copay; Mail Order supply: DH Pharmacy N/A.	30 day supply: National Network Pharmacy \$130 copay. Mail Order supply: National Network Pharmacy N/A.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	30% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	Not covered	* Pre-authorization required.
	Physician/surgeon fees	Deductible and 20% coinsurance *	Deductible and 30% coinsurance *	Not covered	* Pre-authorization required.
If you need immediate medical attention	Emergency room care	\$300 copay (deductible and coinsurance do not apply)	\$300 copay (deductible and coinsurance do not apply)	\$300 copay (deductible and coinsurance do not apply)	Waived if admitted.
	Emergency medical transportation	Deductible and 20% coinsurance	Deductible and 20% coinsurance	Deductible and 20% coinsurance	-----none-----
	Urgent care	\$75 copay (deductible and coinsurance do not apply)	\$75 copay (deductible and coinsurance do not apply)	\$75 copay (deductible and coinsurance do not apply)	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	30% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible Have been met *	Not covered	* Pre-authorization required.

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	Physician/surgeon fees	Deductible and 20% coinsurance *	Deductible and 30% coinsurance *	Not covered	* Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay per visit	\$50 copay per visit	Not covered	
	Inpatient services	20% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	30% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	Not covered	-----none-----
If you are pregnant	Office visits	Deductible and 20% coinsurance	Deductible and 30% coinsurance	Not covered	Preventive visits are \$0
	Childbirth/delivery professional services	20% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	30% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	Not covered	-----none-----
	Childbirth/delivery facility services	20% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	30% coinsurance after Per Occurrence Deductible of \$150 and Annual Deductible have been met *	Not covered	-----none-----

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		Denver Health Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible and 20% coinsurance *	Deductible and 30% coinsurance *	Not covered	* Pre-authorization required. Coverage is limited to 60 visits annually.
	Rehabilitation services	\$25 copay per visit	\$35 copay per visit	Not covered	Coverage is limited to 20 visits annually per type of therapy.
	Habilitation services	\$25 copay per visit	\$35 copay per visit	Not covered	Coverage is limited to 20 visits annually per type of therapy.
	Skilled nursing care	Deductible and 20% coinsurance *	Deductible and 30% coinsurance *	Not covered	* Pre-authorization required. Coverage is limited to 100 days annually.
	Durable medical equipment	Deductible and 20% coinsurance *	Deductible and 30% coinsurance *	Not covered	* Pre-authorization required.
	Hospice services	Deductible and 20% coinsurance *	Deductible and 30% coinsurance *	Not covered	* Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	\$25 copay per visit	\$35 copay per visit	Not covered	Coverage is limited to 1 exam every 24 months.
	Children's glasses	Not covered	Not covered	Not covered	Excluded service.
	Children's dental check-up	Not covered	Not covered	Not covered	Fluoride varnish at PCP visit covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Elective Abortions • Cosmetic Surgery • Dental care (adult) 	<ul style="list-style-type: none"> • Long-term care • Infertility treatment • Routine foot care 	<ul style="list-style-type: none"> • Weight loss programs • Acupuncture • No coverage provided outside of the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Hearing Aids • Routine eye care 	<ul style="list-style-type: none"> • Private-duty nursing (when medically necessary)

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>, or U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Denver Health Medical Plan, Inc. at 1-800-700-8140 or www.denverhealthmedicalplan.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#): \$500
- [Specialist copayment](#) \$50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other [coinsurance](#): 0%

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost **\$12731**

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1560

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#): \$500
- [Specialist copayment](#) \$50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other [coinsurance](#): 0%

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost **\$7460**

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$652
Coinsurance	\$348
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1555

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#): \$500
- [Specialist copayment](#) \$50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other [coinsurance](#): 0%

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost **\$1925**

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$250
Coinsurance	\$283
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1033