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?	$1,350 individual or $2,700 family for In-Network. $2,500 individual or $4,000 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, the overall family deductible must be met before the plan begins to pay.
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?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	$2,700 individual or $5,400 family for In-network. $5,000 individual or $8,000 family for Cofinity Network.	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, all family member's expenses will count towards the overall family out-of-pocket limit.
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.

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	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Specialist visit	Deductible and 10% coinsurance	Deductible and 20% coinsurance	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 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	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 $8 copay (discount); $10 copay (generic); $15 copay (non-preferred generic) Mail Order supply: DH Pharmacy $16 copay (discount); $20 copay (generic); $30 copay (non-preferred generic)	30 day supply: National Network Pharmacy $16 copay (discount); $20 copay (generic); $30 copay (non-preferred generic) Mail Order supply: National Network Pharmacy $32 copay (discount); $40 copay (generic); $60 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). Deductible will apply.
	Preferred brand drugs (Tier 3)	30 day supply: DH Pharmacy $30 copay;	30 day supply: National Network Pharmacy $60 copay.	Not covered	

		Mail Order supply: DH Pharmacy $60 copay.	Mail Order supply: National Network Pharmacy $120 copay.		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). Deductible will apply.
	Non-preferred brand drugs (Tier 4)	30 day supply: DH Pharmacy $35 copay; Mail Order supply: DH Pharmacy $70 Copay.	30 day supply: National Network Pharmacy $70 copay. Mail Order supply: National Network Pharmacy $140 copay.	Not covered	
	Specialty drugs (Tier 5)	30 day supply: DH Pharmacy $40 copay; Mail Order supply: DH Pharmacy N/A.	30 day supply: National Network Pharmacy $80 copay. Mail Order supply: National Network Pharmacy N/A.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	* Pre-authorization required.
	Physician/surgeon fees	Deductible and 10% coinsurance*	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required.
If you need immediate medical attention	Emergency room care	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Waived if admitted.
	Emergency medical transportation	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	---------none----------
	Urgent care	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	---------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible and 10% Coinsurance*	Deductible and 20% Coinsurance*	Not covered	* Pre-authorization required.
	Physician/surgeon fees	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	---------none----------
	Inpatient services	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required.
If you are pregnant	Office visits	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	Preventive visits are $0
	Childbirth/delivery professional services	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Childbirth/delivery facility services	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
If you need help recovering or have other special health needs	Home health care	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required. Coverage is limited to 100 visits per calendar year
	Rehabilitation services	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy.
	Habilitation services	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy.
	Skilled nursing care	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required. Coverage is limited to 100 days per calendar year
	Durable medical equipment	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required.
	Hospice services	Deductible and 10% coinsurance *	Deductible and 20% coinsurance *	Not covered	* Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Excluded service.
	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.)		
• Elective Abortions • Cosmetic Surgery • Dental care (adult)	• Long-term care • Infertility treatment • Routine foot care	• Weight loss programs • Acupuncture • No coverage provided outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care	• Hearing Aids • Routine eye care	• Private-duty nursing (when medically necessary)

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, kwiijigo holne' [insert telephone number].]

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

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: $1350
- Specialist copayment: Deductible and 10% coinsurance
- Hospital (facility): Deductible and 10% 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	$12739

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1350
Copayments	$40
Coinsurance	$1260
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2710

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $1350
- Specialist copayment: Deductible and 10% coinsurance
- Hospital (facility): Deductible and 10% 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	$7400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1350
Copayments	$700
Coinsurance	$293
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2398

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible: $1350
- Specialist copayment: Deductible and coinsurance
- Hospital (facility): Deductible and 10% 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	$1926

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1350
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1543

The plan would be responsible for the other costs of these EXAMPLE covered services.