




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. This is only a summary.** 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](http://www.denverhealthmedicalplan.org) or call 1-800-700-8140 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,450 Individual / \$2,900 Family	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.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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. 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet other deductibles for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For in-network providers \$2,900 individual / \$5,800 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Premiums, balance-billed charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.denverhealthmedicalplan.org">www.denverhealthmedicalplan.org</a> 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 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 receive services. Out-of-network providers are not covered on this plan except for urgent care or emergency.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	Deductible and 10% coinsurance	Not Covered.	-----none-----
	<a href="#">Specialist</a> visit	Deductible and 10% coinsurance	Not Covered.	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	0% Coinsurance	Not Covered.	-----none-----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Deductible and 10% coinsurance	Not Covered.	-----none-----
	Imaging (CT/PET scans, MRIs)	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required for PET and MRI
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.denverhealthmedicalplan.org">www.denverhealthmedicalplan.org</a>	Discount drugs/ Generic drugs/ Non-preferred Generic	<b>30-day supply:</b> DH Pharmacy \$8 copay (discount); \$10 copay (generic); \$15 copay (non-preferred generic)  <b>Mail Order 90-day supply:</b> DH Pharmacy \$16 copay (discount); \$20 copay (generic); \$30 copay (non-preferred generic)	<b>30-day supply:</b> National Network Pharmacy \$16 copay (discount); \$20 copay (generic); \$30 copay (non-preferred generic)  <b>Mail Order 90-day supply:</b> National Network Pharmacy \$32 copay (discount); \$40 copay (generic); \$60 copay (non-preferred generic)	<b><u>Deductible does apply</u></b>  You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a <a href="#">preauthorization</a> requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. 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	<b>30-day supply:</b> DH Pharmacy \$30 copay;  <b>Mail Order 90-day supply:</b> DH Pharmacy \$60 copay	<b>30-day supply:</b> National Network Pharmacy \$60 copay;  <b>Mail Order 90-day supply:</b> National Network Pharmacy \$120 copay	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs	<b>30-day supply:</b> DH Pharmacy \$35 copay;  <b>Mail Order 90-day supply:</b> DH Pharmacy \$70 copay	<b>30-day supply:</b> National Network Pharmacy \$70 copay;  <b>Mail Order 90-day supply:</b> National Network Pharmacy \$140 copay	<u><b>Deductible does apply</b></u>  You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a <a href="#">preauthorization</a> requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. 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).
	<a href="#">Specialty drugs</a>	<b>30-day supply:</b> DH Pharmacy \$40 copay;  <b>Mail Order 90-day supply:</b> DH Pharmacy N/A	<b>30-day supply:</b> National Network Pharmacy \$80 copay;  <b>Mail Order 90-day supply:</b> National Network Pharmacy N/A	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required
	Physician/surgeon fees	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Waived if admitted.
	<a href="#">Emergency medical transportation</a>	Deductible and 10% coinsurance	Deductible and 10% coinsurance	-----none-----
	<a href="#">Urgent care</a>	Deductible and 10% coinsurance	Deductible and 10% coinsurance	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required
	Physician/surgeon fees	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Deductible and 10% coinsurance	Not Covered.	-----none-----
	Inpatient services	Deductible and 10% coinsurance	Not Covered.	-----none-----

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you are pregnant</b>	Office visits	Deductible and 10% coinsurance	Not Covered.	Preventive visits are \$0
	Childbirth/delivery professional services	Deductible and 10% coinsurance	Not Covered.	-----none-----
	Childbirth/delivery facility services	Deductible and 10% coinsurance	Not Covered.	-----none-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required. Coverage limited to 60 visits annually.
	<a href="#">Rehabilitation services</a>	Deductible and 10% coinsurance	Not Covered.	Coverage is limited to 20 visits annually per type of therapy.
	<a href="#">Habilitation services</a>	Deductible and 10% coinsurance	Not Covered.	Coverage is limited to 20 visits annually per type of therapy.
	<a href="#">Skilled nursing care</a>	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required. Coverage limited to 100 days annually.
	<a href="#">Durable medical equipment</a>	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required.
	<a href="#">Hospice services</a>	Deductible and 10% coinsurance*	Not Covered.	*Pre-authorization required.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered.	Not Covered.	Excluded service.
	Children's glasses	Not Covered.	Not Covered.	Excluded service.
	Children's dental check-up	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 Abortion	• Long-term care	• Weight loss programs
• Cosmetic Surgery	• Infertility Treatment	• Acupuncture
• Dental care (adult)	• Routine foot care	• 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.)**

• Bariatric surgery	• Hearing aids	• Private-duty nursing (when medically necessary)
• Chiropractic care	• Routine eye care	

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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](http://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](http://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 on how 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](http://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**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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:**

(Español): Para obtener asistencia en Español, llame al 1-855-823-8872.

(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-823-8872.

(Chinese): (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-823-8872.

(Navajo)(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-823-8872.

*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](#) \$1,450
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,450
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,250
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,700</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,450
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,450
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$718
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,223</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,450
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,450
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$193
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,643</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.