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 or call 1-800-700-8140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 Individual / $0 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.
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. 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 www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services
What is the out-of-pocket limit for this plan?	For in-network providers $3,000 individual / $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 on 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-billed 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 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.
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
		Network Provider (You will pay the least)	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	Not Covered.	---------none----------
	Specialist visit	$40 Copay	Not Covered.	---------none----------
	Preventive care/screening/ immunization	0% Coinsurance	Not Covered.	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance	Not Covered.	---------none----------
	Imaging (CT/PET scans, MRIs)	$200 Copay*	Not Covered.	*Pre-authorization required for PET and MRI
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/ Non-preferred Generic	**30-day supply:** DH Pharmacy $10 copay (discount); $12 copay (generic); $35 copay (non-preferred generic) **Mail Order 90-day 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 90-day supply:** National Network Pharmacy $40 copay (discount); $48 copay (generic); $140 copay (non-preferred generic)	You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization 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	**30-day supply:** DH Pharmacy $45 copay; **Mail Order 90-day supply:** DH Pharmacy $90 copay	**30-day supply:** National Network Pharmacy $90 copay; **Mail Order 90-day supply:** National Network Pharmacy $180 copay	

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	**30-day supply:** DH Pharmacy $55 copay; **Mail Order 90-day supply:** DH Pharmacy $110 copay	**30-day supply:** National Network Pharmacy $110 copay; **Mail Order 90-day supply:** National Network Pharmacy $220 copay	You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization 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).
	Specialty drugs	**30-day supply**: DH Pharmacy $65 copay; **Mail Order 90-day supply:** DH Pharmacy N/A	**30-day supply**: National Network Pharmacy $130 copay; **Mail Order 90-day supply:** National Network Pharmacy N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 Copay*	Not Covered.	*Pre-authorization required
	Physician/surgeon fees	20% Coinsurance*	Not Covered.	*Pre-authorization required
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	Waived if admitted.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	---------none----------
	Urgent care	$50 Copay	$50 Copay	---------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 Copay*	Not Covered.	*Pre-authorization required
	Physician/surgeon fees	0% Coinsurance*	Not Covered.	*Pre-authorization required
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$25 Copay	Not Covered.	---------none----------
	Inpatient services	$500 Copay	Not Covered.	---------none----------
If you are pregnant	Office visits	20% Coinsurance	Not Covered.	Preventive visits are $0
	Childbirth/delivery professional services	20% Coinsurance	Not Covered.	---------none----------
	Childbirth/delivery facility services	20% Coinsurance	Not Covered.	---------none----------

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 need help recovering or have other special health needs	Home health care	20% Coinsurance*	Not Covered.	*Pre-authorization required. Coverage limited to 60 visits annually.
	Rehabilitation services	$50 Copay	Not Covered.	Coverage is limited to 30 visits annually per type of therapy.
	Habilitation services	$50 Copay	Not Covered.	Coverage is limited to 30 visits annually per type of therapy.
	Skilled nursing care	20% Coinsurance*	Not Covered.	*Pre-authorization required. Coverage limited to 100 days annually.
	Durable medical equipment	20% Coinsurance*	Not Covered.	*Pre-authorization required.
	Hospice services	20% Coinsurance*	Not Covered.	*Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	$40 Copay	Not Covered.	Coverage is limited to one exam every 24 months
	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
- Cosmetic Surgery
- Dental care (adult)
- Long-term care
- Infertility Treatment
- Routine foot care
- 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.)

- 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 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, 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, kwiijigo holne' 1-855-823-8872.

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	**$0**
Specialist copayments	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$798
Coinsurance	$479
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,337**

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

The plan's overall deductible	**$0**
Specialist copayments	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,237
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,638**

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

The plan's overall deductible	**$0**
Specialist copayments	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$520
Coinsurance	$158
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,426**

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