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. An embedded plan has individual deductibles and a max out-of-pocket. Cost-sharing begins when the member reaches their individual deductible (including copayment).
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 other deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,350 individual / $8,700 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, all family members' 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 Denver Health and Hospital Authority provider network. The Columbine network is used for chiropractic services. Cofinity providers are in-network for outpatient mental health services only. Please be aware, your network provider may 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?	Yes, for some providers.	For Denver Health and Hospital Authority, you will need a referral to see most specialists.

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/visit	Not Covered	Three PCP visits at $0 cost-sharing per year at Denver Health facilities only.
	Specialist visit	$30 copay/visit	Not Covered	A referral may be required.
	Preventive care/screening/ immunization	$0 copay	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/test	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	$0 copay/CT* $150 copay/PET* $150 copay/MRI*	Not covered	*Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.denverhealthmedicalplan.org	Discount Drugs	**30-day supply:** DH Pharmacy: $4 copay National Network Pharmacy: $8 copay **90-day supply:** DH Pharmacy: $8 copay National Network Pharmacy: $16 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Generic Drugs	**30-day supply:** DH Pharmacy: $15 copay National Network Pharmacy: $30 copay **90-day supply:** DH Pharmacy: $30 copay National Network Pharmacy: $60 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

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 Generic drugs	**30-day supply:** DH Pharmacy: $25 copay National Network Pharmacy: $50 copay **90-day supply:** DH Pharmacy: $50 copay National Network Pharmacy: $100 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	**30-day supply:** DH Pharmacy: $40 copay National Network Pharmacy: $80 copay **90-day supply:** DH Pharmacy: $80 copay National Network Pharmacy: $160 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Non-preferred brand/Preferred Specialty drugs	**30-day supply:** DH Pharmacy: $50 copay National Network Pharmacy: $100 copay copay **90-day supply:** DH Pharmacy: $100 copay National Network Pharmacy: $200 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

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)	
	Specialty drugs	**30-day supply:** DH Pharmacy: $60 copay National Network Pharmacy: $120 copay **90-day supply:** DH Pharmacy: N/A National Network Pharmacy: N/A	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/surgery*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Waived if admitted (Inpatient copay then applies).
	Emergency medical transportation	$150 copay/transport	$150 copay/transport	---------none----------
	Urgent care	$50 copay/visit	$50 copay/visit	Dispatch Health included.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/hospital stay*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Not covered	*Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	Not covered	---------none----------
	Inpatient services	$400 copay/admission*	Not covered	*Pre-authorization required.
If you are pregnant	Office visits	$0 copay/visit	Not covered	Preventive/prenatal visits and one postnatal visit are a $0 copay. Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	$200 copay/admission	Not covered	Cost sharing may apply for additional services.

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	$0 copay*	Not covered	*Pre-authorization required.
	Rehabilitation services	$10 copay/visit	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech).
	Habilitation services	$10 copay/visit	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech).
	Skilled nursing care	$0 copay*	Not covered	*Pre-authorization required. Coverage limited to 100 days per calendar year.
	Durable medical equipment	20% coinsurance*	Not covered	*Pre-authorization may be required.
	Hospice services	$0 copay*	Not covered	*Pre-authorization required. Each benefit period has a duration of three months.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit at Denver Health Eye Clinic or One-Hour Optical	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	$350 reimbursement*	Not covered	*Only one claim may be submitted every 24 months.
	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 abortions
- Cosmetic surgery
- Dental care (adult/child)
- 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.)

- Oxygen
- Chiropractic Care
- Hearing aids
- Routine eye care (adult, child)
- 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 303-602-2100 / 1-800-700-8140.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-602-2100 / 1-800-700-8140.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 303-602-2100 / 1-800-700-8140.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-602-2100 / 1-800-700-8140.

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 copayment	$30
Hospital (facility) copayment	$200
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	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

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 copayment	$30
Hospital (facility) copayment	$400
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	$1,245
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,646**

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

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$400
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	$280
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$287**

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