




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:
What is the overall <a href="#">deductible</a> ?	\$250 individual / \$500 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. An embedded <a href="#">plan</a> has individual <a href="#">deductibles</a> and a max <a href="#">out-of-pocket</a> . Cost-sharing begins when the member reaches their individual <a href="#">deductible</a> (including <a href="#">copayment</a> ).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services and preventive pharmacy are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet other <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,250 individual / \$10,500 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members on this <a href="#">plan</a> , all family members' expenses will count towards the overall family <a href="#">out-of-pocket limit</a> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.denverhealthmedicalplan.org">www.denverhealthmedicalplan.org</a> or call 1-800-700-8140 for a list of network <a href="#">providers</a> .	This <a href="#">plan</a> uses Denver Health and Hospital Authority, UC Health, CU Health Partners, Colorado Pediatric Partners, the Children's Hospital Colorado provider network and Intermountain Health Front Range locations. The Cumbine network is used for chiropractic services. First Health providers in Colorado are in-network for outpatient mental health services only. Conceptions is in-network for infertility services. Please be aware, your network provider may use an out-of-network <a href="#">provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you receive services. Out-of-network <a href="#">providers</a> are not covered on this <a href="#">plan</a> except for urgent care or emergency.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, for some <a href="#">providers</a> .	For Denver Health and Hospital Authority, you will need a <a href="#">referral</a> to see most <a href="#">specialists</a> . Within the HighPoint network, you do not need a <a href="#">referral</a> for claim payment, but the <a href="#">specialist</a> may request a <a href="#">referral</a> from your PCP prior to care.

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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</a> office or clinic	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> /visit after deductible	Not covered	Three PCP visits at \$0 cost-sharing per year at Denver Health facilities only.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit after deductible	Not covered	A <a href="#">referral</a> may be required.
	<a href="#">Preventive care/screening/immunization</a>	\$0 <a href="#">copay</a>	Not covered	-----none-----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$0 <a href="#">copay</a> /test after deductible	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$0 <a href="#">copay</a> /CT* after deductible \$150 <a href="#">copay</a> /PET* after deductible \$250 <a href="#">copay</a> /MRI* after deductible	Not covered	*Pre-authorization required.
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	30-day supply: <a href="#">DH Pharmacy</a> : \$4 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : \$8 <a href="#">copay</a>  90-day supply: <a href="#">DH Pharmacy</a> : \$8 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : \$16 <a href="#">copay</a>	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Generic Drugs	30-day supply: <a href="#">DH Pharmacy</a> : \$15 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : \$30 <a href="#">copay</a>  90-day supply: <a href="#">DH Pharmacy</a> : \$30 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : \$60 <a href="#">copay</a>	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

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

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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)	
	<a href="#">Specialty drugs</a>	<b>30-day supply:</b> <a href="#">DH Pharmacy:</a> \$60 <a href="#">copay</a> <a href="#">National Network Pharmacy:</a> \$120 <a href="#">copay</a>  <b>90-day supply:</b> <a href="#">DH Pharmacy:</a> N/A <a href="#">National Network Pharmacy:</a> 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)	\$400 <a href="#">copay</a> /surgery* after deductible	Not covered	*Pre-authorization required.
	Physician/surgeon fees	(Included in <a href="#">copayment</a> above)*	Not covered	*Pre-authorization required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$300 <a href="#">copay</a> /visit after deductible	\$300 <a href="#">copay</a> /visit after deductible	Waived if admitted (Inpatient copay then applies).
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copay</a> /transport after deductible	\$150 <a href="#">copay</a> /transport after deductible	-----none-----
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit after deductible	\$50 <a href="#">copay</a> /visit	DispatchHealth included.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 <a href="#">copay</a> /hospital stay* after deductible	Not covered	*Pre-authorization required.
	Physician/surgeon fees	(Included in <a href="#">copayment</a> above)*	Not covered	*Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /visit after deductible	Not covered	-----none-----
	Inpatient services	\$600 <a href="#">copay</a> /admission* after deductible	Not covered	*Pre-authorization required.
If you are pregnant	Office visits	\$0 <a href="#">copay</a> /visit	Not covered	Preventive/prenatal visits and one postnatal visit are a \$0 <a href="#">copay</a> . Cost sharing may apply for additional services.

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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)	
	Childbirth/delivery professional/facility services	\$400 <a href="#">copay</a> /admission after deductible	Not covered	Cost sharing may apply for additional services.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$0 <a href="#">copay</a> * after deductible	Not covered	*Pre-authorization may be required.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit after deductible	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech).
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> /visit after deductible	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech).
	<a href="#">Skilled nursing care</a>	\$0 <a href="#">copay</a> * after deductible	Not covered	*Pre-authorization may be required. Coverage limited to 100 days per calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> * after deductible	Not covered	*Pre-authorization may be required.
	<a href="#">Hospice services</a>	\$0 <a href="#">copay</a> * after deductible	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	\$40 <a href="#">copay</a> /visit at Denver Health Eye Clinic or One-Hour Optical after deductible	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.

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**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        | • Long-term care       | • Acupuncture                           |
| • Cosmetic surgery          | • Weight loss programs | • No coverage provided outside the U.S. |
| • Dental care (adult/child) | • Routine foot care    |   |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                     |                                   |   |
|---------------------|-----------------------------------|---|
| • Oxygen            | • Hearing aids                    | • Infertility treatment                           |
| • Chiropractic care | • 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](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 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**

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, kwijigo 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.*

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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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$600
■ Other <a href="#">coinsurance</a>	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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$0

What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$1,520

## Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$600
■ Other <a href="#">coinsurance</a>	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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

What isn't covered	
Limits or exclusions	\$4,400
The total Joe would pay is	\$4,950

## Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$250
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$600
■ Other <a href="#">coinsurance</a>	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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$50

What isn't covered	
Limits or exclusions	\$300
The total Mia would pay is	\$1,600

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

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