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?	Denver Health Network: $0 individual / $0 family. Extended Network: $2,000 individual / $4,000 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?	$6,500 individual / $13,000 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, 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 has two network options. You will pay the least within the Denver Health Network which includes Denver Health and Hospital Authority providers and facilities. The Extended Network includes UC Health, CU Health Partners, Colorado Pediatric Partners, Children's Hospital Colorado, Intermountain Health (front range locations), Advent Health and First Health providers nationwide (excludes HCA HealthONE). The Columbine network is used for chiropractic services. Conceptions is in-network for infertility services. 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. Within the Extended Network, you do not need a referral for claim payment, but the specialist may request a referral from your PCP prior to care.

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)	Extended Network Provider (You will pay more)	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	$15 copay/visit	$75 copay/visit	Not covered	---------none----------
	Specialist visit	$40 copay/visit	$125 copay/visit	Not covered	A referral may be required.
	Preventive care/screening/ immunization	$0 copay	$0 copay	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/test	20% coinsurance	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	$150 copay*	20% coinsurance after deductible*	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	Preferred Generics	**30-day supply:** DH Pharmacy: $15 copay **100-day supply:** DH Pharmacy: $30 copay	**30-day supply:** National Network Pharmacy: $30 copay **100-day supply:** National Network Pharmacy: $60 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-100-day supply (mail order prescription).

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)	Extended Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Preferred Brand	**30-day supply:** DH Pharmacy: $25 copay National **100-day supply:** DH Pharmacy: $50 copay	**30-day supply:** National Network Pharmacy: 20% coinsurance **100-day supply:** National Network Pharmacy: 20% coinsurance	Not covered	Covers up to a 30-day supply (retail prescription); 31-100-day supply (mail order prescription).
	Preferred Specialty	**30-day supply:** DH Pharmacy: $60 copay	**30-day supply:** National Network Pharmacy: 25% coinsurance	Not covered	Covers up to a 30-day supply (retail prescription).
	Non-Preferred	**30-day supply:** DH Pharmacy: $100 copay	**30-day supply:** National Network Pharmacy: 30% coinsurance	Not covered	Covers up to a 30-day supply (retail prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	$350 copay/surgery*	20% coinsurance after deductible*	Not covered	*Pre-authorization may be required.
If you need immediate medical attention	Emergency room care	$300 copay/visit	$300 copay/visit	$300 copay/visit	Waived if admitted (Inpatient copay then applies).
	Emergency medical transportation	$150 copay/transport	$150 copay/transport	$150 copay/transport	---------none----------

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)	Extended Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Urgent care	DHHA Urgent Care: $30 copay/visit	$70 copay/visit	$70 copay/visit	DispatchHealth included at $70 copay/visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$750 copay/hospital stay*	20% coinsurance after deductible*	Not covered	*Pre-authorization may be required.
	Physician/surgeon fees				
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	$15 copay/visit	Not covered	1 free mental health wellness exam per year.
	Inpatient services	$750 copay/admission*	$750 copay/admission*	Not covered	*Pre-authorization may be required.
If you are pregnant	Office visits	$15 copay/visit	$75 copay/visit	Not covered	Preventive visits are a $0 copay. Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	$350 copay/admission	20% coinsurance after deductible	Not covered	Cost sharing may apply for additional services. Inpatient coverage for doulas is available at in-network providers.
If you need help recovering or have other special health needs	Home health care	10% coinsurance*	20% coinsurance after deductible*	Not covered	*Pre-authorization required after 60-days.
	Rehabilitation services	$40 copay/visit	$40 copay/visit	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech) unless medically necessary.

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)	Extended Network Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$40 copay/visit	$40 copay/visit	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech) unless medically necessary.
	Skilled nursing care	10% coinsurance	20% coinsurance after deductible	Not covered	Coverage limited to 100 days per calendar year.
	Durable medical equipment	10% coinsurance*	20% coinsurance after deductible*	Not covered	*Pre-authorization may be required.
	Hospice services	10% coinsurance	20% coinsurance after deductible	Not covered	Each benefit period has a duration of three months.
If your child needs dental or eye care	Children's eye exam	$40 copay/visit	$40 copay/visit	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	$350 reimbursement	$350 reimbursement	Not covered	Only one claim may be submitted every 24 months.
	Children's dental check-up	Not covered	Not covered	Not covered	Only 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
- Weight loss programs
- Routine foot care
- Acupuncture
- Coverage 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)
- Infertility treatment
- 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	$40
Hospital (facility) copayment	$750
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,860**

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	$40
Hospital (facility) copayment	$750
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$750
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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,420**

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