




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> ?	\$0 individual / \$0 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> ?	\$5,000 individual / \$10,000 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 provider network. The Columbine 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> .

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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	\$15 <a href="#">copay</a> /visit	Not covered	-----none-----
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	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	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copay</a>	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>	Preferred Generics	<b>30-day supply:</b> <a href="#">DH Pharmacy</a> : \$15 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : \$30 <a href="#">copay</a>  <b>100-day supply:</b> <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); 31-100-day supply (mail order prescription).
	Preferred Brand	<b>30-day supply:</b> <a href="#">DH Pharmacy</a> : \$25 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : 20% coinsurance  <b>100-day supply:</b> <a href="#">DH Pharmacy</a> : \$50 <a href="#">copay</a> <a href="#">National Network Pharmacy</a> : 20% coinsurance	Not covered	Covers up to a 30-day supply (retail prescription); 31-100-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)	
	Preferred Specialty	<b>30-day supply:</b> <u>DH Pharmacy:</u> \$60 <a href="#">copay</a> <u>National Network Pharmacy:</u> 25% coinsurance	Not covered	Covers up to a 30-day supply (retail prescription).
	Non-Preferred	<b>30-day supply:</b> <u>DH Pharmacy:</u> \$100 <a href="#">copay</a> <u>National Network Pharmacy:</u> 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)	\$350 <a href="#">copay</a> /surgery*	Not covered	*Pre-authorization may be required.
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$300 <a href="#">copay</a> /visit	\$300 <a href="#">copay</a> /visit	Waived if admitted (Inpatient copay then applies).
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copay</a> /transport	\$150 <a href="#">copay</a> /transport	-----none-----
	<a href="#">Urgent care</a>	<u>DHHA Urgent Care:</u> \$30 <a href="#">copay</a>	\$70 <a href="#">copay</a> /visit	DispatchHealth included at \$70 copay/visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 <a href="#">copay</a> /hospital stay*	Not covered	*Pre-authorization may be required.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <a href="#">copay</a> /visit	Not covered	1 free mental health wellness exam per year.
	Inpatient services	\$750 <a href="#">copay</a> /admission*	Not covered	*Pre-authorization may be required.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$15 <a href="#">copay</a> /visit	Not covered	Preventive visits are a \$0 <a href="#">copay</a> . Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	\$350 <a href="#">copay</a> /admission	Not covered	Cost sharing may apply for additional services. Inpatient coverage for doulas is available at DHHA.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% coinsurance*	Not covered	*Pre-authorization required after 60-days.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech) unless medically necessary.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit	Not covered	Coverage is limited to 30 visits per calendar year per type of therapy (occupational, physical, speech) unless medically necessary.
	<a href="#">Skilled nursing care</a>	10% coinsurance	Not covered	Coverage limited to 100 days per calendar year.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> *	Not covered	*Pre-authorization may be required.
	<a href="#">Hospice services</a>	10% coinsurance	Not covered	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 EyeCare Specialties of Colorado	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	Only 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 | • Coverage 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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$750
■ Other <a href="#">coinsurance</a>	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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,800
<a href="#">Coinsurance</a>	\$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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$750
■ Other <a href="#">coinsurance</a>	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
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$750
■ Other <a href="#">coinsurance</a>	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
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$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.

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