
 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 1-855-823-8872. 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.healthcare.gov/sbc-glossary or call 1-855-823-8872 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	Generally, you must pay all 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.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable	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 must meet their own out-of-pocket limits until the overall family out-of-pocket limit is met.
What is not included in the out-of-pocket limit ?	Not Applicable	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/find-doctor or call 1-855-823-8872 for a list of network providers .	This plan uses a provider network . You pay less when using a provider in the plan's network . You pay more if you use an out-of-network provider , and you may receive a bill from a provider for the difference of the provider's charge and what your plan pays (balance billing). Your network provider may use an out-of-network provider for some services. Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	This plan will pay some or all of the costs to see a specialist for covered services if you have a referral before you see the specialist .

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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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	100% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	0% <u>coinsurance</u>	100% <u>coinsurance</u>	-----none-----
	Other practitioner office visit	0% <u>coinsurance</u>	100% <u>coinsurance</u>	Care must be received by a Columbine Chiropractic provider. Coverage is limited to 20 visits annually.
	<u>Preventive care/screening/immunization</u>	0% <u>coinsurance</u>	100% <u>coinsurance</u>	-----none-----
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	100% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	100% <u>coinsurance</u>	Pre-authorization required.

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)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.denverhealthmedicalplan.org/elevate-current-members</p>	Generic drugs	Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: 0% coinsurance Non-Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: 0% coinsurance	100% coinsurance	Deductible does not apply.
	Preferred brand drugs	Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: 0% coinsurance Non-Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: 0% coinsurance	100% coinsurance	Deductible does not apply.
	Non-preferred brand drugs	Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: 0% coinsurance Non-Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: 0% coinsurance	100% coinsurance	Deductible does not apply.
	Specialty drugs	Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: N/A Non-Denver Health Pharmacy: 30 Day: 0% coinsurance 90 Day: N/A	100% coinsurance	Deductible does not apply.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	100% coinsurance	Pre-authorization required.
	Physician/surgeon fees	0% coinsurance	100% coinsurance	Pre-authorization required.
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	-----none-----
	Emergency medical transportation	0% coinsurance	0% coinsurance	-----none-----
	Urgent care	0% coinsurance	0% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	100% coinsurance	Pre-authorization required.
	Physician/surgeon fees	0% coinsurance	100% coinsurance	Pre-authorization required.
If you need mental health, behavioral health, or substance use services	Mental/behavioral health/substance use disorder outpatient services	0% coinsurance	100% coinsurance	-----none-----
	Mental/behavioral health/substance use disorder inpatient services	0% coinsurance	100% coinsurance	Pre-authorization required.
If you are pregnant	Office visits	0% coinsurance	100% coinsurance	-----none-----
	Childbirth/delivery professional services	0% coinsurance	100% coinsurance	-----none-----
	Childbirth/delivery facility services	0% coinsurance	100% coinsurance	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	100% coinsurance	Pre-authorization required.
	Rehabilitation services	0% coinsurance	100% coinsurance	Coverage is limited to 20 visits annually per type of therapy.
	Habilitation services	0% coinsurance	100% coinsurance	Coverage is limited to 20 visits annually per type of therapy.
	Skilled nursing care	0% coinsurance	100% coinsurance	Pre-authorization required. Coverage is limited to 100 days per year.

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)	
	Durable medical equipment	0% coinsurance	100% coinsurance	Pre-authorization required.
	Hospice services	0% coinsurance	100% coinsurance	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	0% coinsurance	100% coinsurance	Coverage is limited to one routine eye exam per child per 12 months.
	Children's glasses	0% coinsurance	100% coinsurance	Coverage is limited to one pair per 24-month period per child age 18 and under.
	Children's dental check-up	100% coinsurance	100% coinsurance	Coverage is available through a stand-alone dental policy (SADP).

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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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
- Infertility treatment
- Private-duty nursing (when medically necessary)
- Routine eye care

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 www.dol.gov/agencies/ebsa, or the 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

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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: Elevate Health Plans at 1-855-823-8872 or www.denverhealthmedicalplan.org/elevate-current-members, or the Department of Labor's Employee Benefits Security Administration at 1- 866-444-EBSA (3272) or 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](#).

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](#) coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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	\$0
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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](#) coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$0

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

- The [plan's](#) overall [deductible](#): \$8,150
- [Specialist](#) coinsurance: 0%
- Hospital (facility) coinsurance: 0%
- Other coinsurance: 0%

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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Language Access Services:

(Spanish) Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Denver Health Medical Plan, Inc. tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-823-8872.

(Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Denver Health Medical Plan, Inc. quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-823-8872.

(Chinese) 如果您或您正在幫助的人有關於Denver Health Medical Plan, Inc. 方面的問題您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話請致電 1-855-823-8872。

(Korean) 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Denver Health Medical Plan, Inc. 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-823-8872로 전화하십시오.

(Russian) Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Denver Health Medical Plan, Inc. то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-823-8872.

(Amharic) እርስዎ፣ ወይም እርስዎ የሚያገዙት ግለሰብ፣ ስለ Denver Health Medical Plan, Inc. ጥያቄላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-855-823-8872 ይደውሉ።

(Arabic) نناكلكم بيدينا وأني نبدلصصخشدهددعاستهألسأصصووصخب Denver Health Medical Plan, Inc. كلكم بيدينا
بالتصال 1-855-823-8872.

(German) Falls Sie oder jemand, dem Sie helfen, Fragen zum Denver Health Medical Plan, Inc. haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-823-8872 an.

(French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Denver Health Medical Plan, Inc. vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-823-8872.

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