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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,400 / individual or $2,800 / family.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care services and preventive pharmacy are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $1,950 individual / $3,900 family.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.denverhealthmedicalplan.org/find-doctor">www.denverhealthmedicalplan.org/find-doctor</a> or call 1-855-823-8872 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes. Self-referral to First Health providers in Colorado is allowed for outpatient mental health services only.</td>
<td>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.</td>
</tr>
</tbody>
</table>

Questions: Call 1-855-823-8872 or visit us at www.denverhealthmedicalplan.org. See the Glossary for underlined items. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-823-8872 to request a copy.
### Overview of Benefits and Coverage

**What this Plan Covers & What You Pay For Covered Services**

**Coverage Period:** 1/1/2023-12/31/2023

**Denver Health Medical Plan, Inc.: Elevate Silver Standard Rx Copay 87%**

**Plan Type:** HMO

---

**All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>15% coinsurance after deductible/visit</td>
<td>100% coinsurance</td>
<td>[---------------------none----------------]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15% coinsurance after deductible/visit</td>
<td>100% coinsurance</td>
<td>[---------------------none----------------]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15% coinsurance after deductible for chiropractor</td>
<td>100% coinsurance</td>
<td>Care must be received by a Columbine Chiropractic provider. Coverage is limited to 20 visits annually.</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>100% coinsurance</td>
<td>[---------------------none----------------]</td>
<td></td>
</tr>
</tbody>
</table>

If you have a test

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](http://www.denverhealthmedicalplan.org/elevate-current-members)

Preventive Care medications are provided with no cost-sharing, regardless of tier.

Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.

Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.

---

**Questions:** Call **1-855-823-8872** or visit us at [www.denverhealthmedicalplan.org](http://www.denverhealthmedicalplan.org). See the **Glossary** for underlined items. You can view the **Glossary** at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-855-823-8872 to request a copy.
## Summary of Benefits and Coverage:
### What this Plan Covers & What You Pay For Covered Services

**Denver Health Medical Plan, Inc.: Elevate Silver Standard Rx Copay 87%**

**Coverage Period:** 1/1/2023-12/31/2023

**Coverage for:** Individual + Family  |  **Plan Type:** HMO

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
</tbody>
</table>

### 90 Day: $50 copay

- Non-Denver Health Pharmacy
- 30 Day: $50 copay
- 90 Day: $100 copay

**Limitations:**
- Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.

### 30 Day: $50 copay

- Denver Health Pharmacy:
- 30 Day: $60 copay
- 90 Day: $120 copay

**Limitations:**
- Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).

### 90 Day: $100 copay

- Non-Denver Health Pharmacy:
- 30 Day: $120 copay
- 90 Day: $240 copay

**Limitations:**
- Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.

### 90 Day: $120 copay

- Non-preferred brand/Preferred Specialty drugs (Tier 4)
- Denver Health Pharmacy:
- 30 Day: $60 copay
- 90 Day: $120 copay

**Limitations:**
- Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).

### 90 Day: $120 copay

- Specialty drugs (Tier 5)
- Denver Health Pharmacy:
- 30 Day: $120 copay
- 90 Day: N/A

**Limitations:**
- Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).

### 30 Day: $60 copay

- Non-Denver Health Pharmacy:
- 90 Day: $120 copay

**Limitations:**
- Drugs listed in the formulary as Medical Service Drugs (Tier 6) will have applicable out-of-pocket amounts according to the plan's medical benefit.

### 30 Day: $120 copay

- Physician/surgeon fees

**Limitations:**
- Pre-authorization required.

### Facility fee (e.g., ambulatory surgery center)

- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### Facility fee (e.g., hospital room)

- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### Emergency room care

- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### Emergency medical transportation

- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### Urgent care

- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### If you need immediate medical attention

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Network Provider (You will pay the least)</strong></td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong></td>
<td></td>
</tr>
</tbody>
</table>

### If you have outpatient surgery

- Facility fee (e.g., ambulatory surgery center):
- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### If you have a hospital stay

- Facility fee (e.g., hospital room):
- 15% coinsurance after deductible

**Limitations:**
- Pre-authorization required.

### Questions:
Call 1-855-823-8872 or visit us at [www.denverhealthmedicalplan.org](http://www.denverhealthmedicalplan.org). See the Glossary for underlined items. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-855-823-8872 to request a copy.
### Summary of Benefits and Coverage:

**What this Plan Covers & What You Pay For Covered Services**

**Denver Health Medical Plan, Inc.: Elevate Silver Standard Rx Copay 87%**

**Coverage Period:** 1/1/2023-12/31/2023

**Coverage for:** Individual + Family  |  **Plan Type:** HMO

#### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Childbirth/delivery professional/facility services</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Hospice services</td>
<td>15% coinsurance after deductible</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No Charge</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>No Charge</td>
<td>100% coinsurance</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>100% coinsurance</td>
<td>100% coinsurance</td>
</tr>
</tbody>
</table>

#### Questions:
Call 1-855-823-8872 or visit us at [www.denverhealthmedicalplan.org](http://www.denverhealthmedicalplan.org). See the Glossary for underlined items. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-855-823-8872 to request a copy.
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
<th>Services Your Plan Generally Does COVER (Check your policy or plan document for more information about limitations and exclusions.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</td>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery</td>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Routine foot care</td>
<td>• Private-duty nursing (when medically necessary)</td>
</tr>
<tr>
<td>• Weight loss programs</td>
<td>• Routine eye care</td>
</tr>
</tbody>
</table>

**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.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**Questions:** Call 1-855-823-8872 or visit us at www.denverhealthmedicalplan.org. See the Glossary for underlined items. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-823-8872 to request a copy.
**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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible:</strong> $1,400</td>
<td><strong>The plan’s overall deductible:</strong> $1,400</td>
<td><strong>The plan’s overall deductible:</strong> $1,400</td>
</tr>
<tr>
<td><strong>Specialist copayment:</strong> 15% coinsurance after deductible</td>
<td><strong>Specialist copayment:</strong> 15% coinsurance after deductible</td>
<td><strong>Specialist copayment:</strong> 15% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance:</strong> 15% coinsurance after deductible</td>
<td><strong>Hospital (facility) coinsurance:</strong> 15% coinsurance after deductible</td>
<td><strong>Hospital (facility) coinsurance:</strong> 15% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Other coinsurance:</strong> 100%</td>
<td><strong>Other coinsurance:</strong> 100%</td>
<td><strong>Other coinsurance:</strong> 100%</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$5,600</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

| Cost Sharing | Deductibles | $1,400 |
| Copayments | $0 |
| Coinsurance | $500 |

*What isn’t covered*
- Limits or exclusions | $60 |

The total Peg would pay is | $1,960 |

| Cost Sharing | Deductibles | $1,200 |
| Copayments | $800 |
| Coinsurance | $20 |

*What isn’t covered*
- Limits or exclusions | $20 |

The total Joe would pay is | $1,970 |

| Cost Sharing | Deductibles | $1,400 |
| Copayments | $10 |
| Coinsurance | $200 |

*What isn’t covered*
- Limits or exclusions | $0 |

The total Mia would pay is | $1,610 |

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 thống 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 사람이Denver Health Medical Plan, Inc.에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 이용 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፣ ኈይም እርስዎየሚያግዙት天空部落 ${Denver Health Medical Plan, Inc.}$ ሆይ ያለውን በጭእ እርዳታና መረጃ በማግኘት መብት አላችሁ። ከአስተርጓሚ ጎር እንታው ከ1-855-823-8872 የታይፋ።

(Arabic) فلدى ${Denver Health Medical Plan, Inc.}$، إذا كنت مُساعدًا على شخصًا، أو نظيره، يُمكنك الحصول على السؤال ولكن بدون تكلفة. يمكنكم التواصل مع مرشدهم على 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.

(Nepali) यदि तपाईं असाना कसरि अथर्वै आपल्लोंको काम गर्ने, त्यसलाई प्रमुख र मैनेजमेंट हुँदै, ${Denver Health Medical Plan, Inc.}$ 

(Tagalog) Kung ikaw, o ang iyong tinitulungan, ay may mga katanungan tungkol sa Denver Health Medical Plan, Inc. may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makaasausap ang isang tagasalin, tumawag sa 1-855-823-8872.

Questions: Call 1-855-823-8872 or visit us at www.denverhealthmedicalplan.org. See the Glossary for underlined items. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-823-8872 to request a copy.
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