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?	$2,750 / individual or $5,500 / family.	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. 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. 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?	For network providers $7,000 individual / $14,000 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, 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?	Premiums, balance-billed charges and health care this plan doesn't cover.	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?	Yes. Self-referral to First Health providers in Colorado is allowed for outpatient mental health services only.	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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance, deductible does not apply	100% coinsurance	[----------none----------]
	Specialist visit	10% coinsurance after deductible/visit	100% coinsurance	[----------none----------]
	Other practitioner office visit	10% coinsurance after deductible for chiropractor	100% coinsurance	Care must be received by a Columbine Chiropractic provider. Coverage is limited to 20 visits annually.
	Preventive care/screening/ immunization	No Charge	100% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance, deductible does not apply/test	100% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible/test	100% coinsurance	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/elevate-current-members	Preventive drugs (Tier 1)	No Charge	100% coinsurance	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.
	Generic drugs (Tier 2)	Denver Health Pharmacy: 30 Day: $15 copay 90 Day: $30 copay Non-Denver Health Pharmacy 30 Day: $30 copay 90 Day: $60 copay	100% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription). 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.
	Preferred brand drugs (Tier 3)	Denver Health Pharmacy: 30 Day: $25 copay	100% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).

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)	
		90 Day: $50 copay Non-Denver Health Pharmacy 30 Day: $50 copay 90 Day: $100 copay		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.
	Non-preferred brand/Preferred Specialty drugs (Tier 4)	Denver Health Pharmacy: 30 Day: $55 copay 90 Day: $110 copay Non-Denver Health Pharmacy 30 Day: $110 copay 90 Day: $220 copay	100% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription). 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.
	Specialty drugs (Tier 5)	Denver Health Pharmacy: 30 Day: $580 copay 90 Day: N/A Non-Denver Health Pharmacy 30 Day: $580 copay 90 Day: N/A	100% coinsurance	Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription). 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Physician/surgeon fees	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
	Urgent care	10% coinsurance after deductible	10% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	100% coinsurance	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)	
	Physician/surgeon fees	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient Services	10% coinsurance after deductible	100% coinsurance	----------none----------
	Inpatient Services	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
If you are pregnant	Office visits	10% coinsurance after deductible	100% coinsurance	Preventive/prenatal visits and one postnatal visit are a $0 copay. Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	10% coinsurance after deductible	100% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Rehabilitation services	10% coinsurance after deductible	100% coinsurance	Coverage is limited to 30 visits annually per type of therapy.
	Habilitation services	10% coinsurance after deductible	100% coinsurance	Coverage is limited to 30 visits annually per type of therapy.
	Skilled nursing care	10% coinsurance after deductible	100% coinsurance	Pre-authorization required. Coverage is limited to 100 days per year.
	Durable medical equipment	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Hospice services	10% coinsurance after deductible	100% coinsurance	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	No Charge	100% coinsurance	----------none----------
	Children's glasses	No Charge	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	Only dental coverage is fluoride varnish at PCP visit.

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)
- Cosmetic surgery
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Private-duty nursing (when medically necessary)
- Routine eye care
- Transgender hormone therapy and surgical procedures

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 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: $2,750
- Specialist copayment: 10% coinsurance after deductible
- Hospital (facility) coinsurance: 10% coinsurance after deductible
- Other coinsurance: 100%

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	$2,750
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,820

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible: $2,750
- Specialist copayment: 10% coinsurance after deductible
- Hospital (facility) coinsurance: 10% coinsurance after deductible
- Other coinsurance: 100%

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	$1,100
Copayments	$1,400
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,600

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

- The plan's overall deductible: $2,750
- Specialist copayment: 10% coinsurance after deductible
- Hospital (facility) coinsurance: 10% coinsurance after deductible
- Other coinsurance: 100%

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	$2,300
Copayments	$10
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,320

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 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 사람이Denver Health Medical Plan, Inc. 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는1-855-823-8872로 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፣ ወይምእርስዎየሚያግዙትግለሰብ፣ ስለDenver Health Medical Plan, Inc. ጥያቄካላቸሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላቸሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-855-823-8872 ይደውሉ።

(Arabic)فلديكك Denver Health Medical Plan, Inc.نن لدىيكككان أوو لدىيأسئلة تساعدهشخص بخصووص

اتصل بـ 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 आफ्ना लागि आफैं आवेदनको काम गर्दै, वा कसैलाई मद्दत गर्दै हुनुहुन्छ, Denver Health Medical Plan, Inc. बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नुपरे 1 855 823 8872 मा फोन गर्नुहोस् ।

(Tagalog) Kung ikaw, o ang iyong tinutulangan, 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 makausap ang isang tagasalin, tumawag sa 1-855-823-8872.

(Japanese) ご本人様、またはお客様の身の回りの方でも Denver Health Medical Plan, Inc. についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-855-823-8872 までお電話ください。

(Cushite) Isin yookan namni biraa isin deeggartan Denver Health Medical Plan, Inc. irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-855-823-8872 tiin bilbilaa.

ردوورم دررد للاووس ,, میبکنیید کمکووا بهه شما کهه کسی بیا,,لمشد ررگااههتشاادد اشییدب حقنن‌یباا اارر ددیبیراادد کهه کمک‌ووتتااعلاططاا بهه ززبانن خوودد اارر بهه ططوورر ننااگیاارر تتفاییررد Denver Health Medical Plan, Inc. (Persian) . نماییید
صاحلل‌تماسس 8872-823-855-1 باامن ییید

(Kru) I bale we, tole mut u ye hola, a gwee mbarga inyu Denver Health Medical Plan, Inc. U gwee Kunde I kosna mahola ni biniiguene i hop wong nni nsaa wogui wo. I Nyu ipot ni mut a nla koblene we hop, sebel 1-855-823-8872.