

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services




**ELEVATE
HEALTH PLANS**

Denver Health Medical Plan Inc..

Colorado Option Silver 73%

Coverage Period: 1/1/2024-12/31/2024


Coverage for: Individual + Family | Plan Type: HMO

 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 ? | \$3,450 / individual or \$6,900 / 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 \$7,450 individual / \$14,900 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. |

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| | | |
|--|--|---|
| Do you need a referral to see a specialist ? | Yes. Self-referral is allowed for OBGYN and outpatient mental health services. | 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 | \$0 copay/visit | 100% coinsurance | [-----none-----] |
| | Specialist visit | \$80 copay/visit | 100% coinsurance | [-----none-----] |
| | Other practitioner office visit | \$80 copay 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) | 40% coinsurance after deductible/test | 100% coinsurance | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance after deductible/test | 100% coinsurance | Pre-authorization required. |

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|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| 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: \$10 copay 90 Day: \$20 copay Non-Denver Health Pharmacy 30 Day: \$20 copay 90 Day: \$40 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: \$62 copay 90 Day: \$125 copay Non-Denver Health Pharmacy 30 Day: \$125 copay 90 Day: \$250 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. |
| | Non-preferred brand/Preferred Specialty drugs (Tier 4) | Denver Health Pharmacy: 30 Day: \$150 copay 90 Day: \$300 copay Non-Denver Health Pharmacy 30 Day: \$300 copay 90 Day: \$600 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: \$325 copay 90 Day: N/A Non-Denver Health Pharmacy 30 Day: \$600 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. |

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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) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Physician/surgeon fees | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| If you need immediate medical attention | Emergency room care | 40% coinsurance after deductible | 40% coinsurance after deductible | -----none----- |
| | Emergency medical transportation | 40% coinsurance after deductible | 40% coinsurance after deductible | -----none----- |
| | Urgent care | \$80 copay | \$80 copay | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Physician/surgeon fees | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient Services | No charge for office visits, other outpatient services 40% coinsurance after deductible | 100% coinsurance | -----none----- |
| | Inpatient Services | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| If you are pregnant | Office visits | \$0 copay | 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 | 40% coinsurance after deductible | 100% coinsurance | -----none----- |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Rehabilitation services | 40% coinsurance after deductible | 100% coinsurance | Coverage is limited to 30 visits annually per type of therapy. |
| | Habilitation services | 40% coinsurance after deductible | 100% coinsurance | Coverage is limited to 30 visits annually per type of therapy. |
| | Skilled nursing care | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. Coverage is limited to 100 days per year. |
| | Durable medical equipment | 40% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |

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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) | |
| | Hospice services | 40% 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](#).)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Abortion (except in cases of rape, incest, or when the life of the mother is endangered) • Cosmetic surgery | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs • Dental care |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Transgender hormone therapy and surgical procedures | <ul style="list-style-type: none"> • Private-duty nursing (when medically necessary) • Routine eye care (child) • Acupuncture |
|--|--|--|

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.

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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.

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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 [plan's](#) overall [deductible](#): \$3,450
- [Specialist](#) copayment: \$80 copay
- [Hospital \(facility\) coinsurance](#): 40% 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,450 |
| Copayments | \$10 |
| Coinsurance | \$3,600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,120 |

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

- The [plan's](#) overall [deductible](#): \$3,450
- [Specialist](#) copayment: \$80 copay
- [Hospital \(facility\) coinsurance](#): 40% 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$1,600 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,520 |

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

- The [plan's](#) overall [deductible](#): \$3,450
- [Specialist](#) copayment: \$80 copay
- [Hospital \(facility\) coinsurance](#): 40% 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$2,500 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,700 |

Language Access Services:

The [plan](#) would be responsible for the other costs of these EXAMPLE covered 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 የሚያግዙት ግለሰብ፣ ስለ Denver Health Medical Plan, Inc. ጥያቄዎችህ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-855-823-8872 ይደውሉ።

(Arabic) بخصوص أسئلة تساعدده شخص ص لددى ألو لددبيك كازن Denver Health Medical Plan, Inc. فلدديكك 1-855-823-8872 ب الاتصال

(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 गनसुरे 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、情報を入力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。

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(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.

مووردددرر للااوسد،، مييكنييدد كمك وواا بهه شما كهه كسي بيا،، امشرر گااله تشاادد باشييدد حقن بياا ارر دديبرر ادكهه كمك ووتت اعلاططاا بهه ز زبان خودد ارر بهه ططوررن ناگييارر نتفايررد (Persian) Denver Health Medical Plan, Inc. نمایييدد
بيينامند 1-855-823-8872 سهامند لل صاحب

(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.

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