

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



**ELEVATE  
HEALTH PLANS**

Denver Health Medical Plan Inc..

Denver Health Medical Plan, Inc.: Elevate Health Plans Colorado Option Gold NA

Coverage Period: 1/1/2025-12/31/2025

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](http://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 <a href="#">deductible</a> ?	\$1,875 / individual or \$3,750 / family.	Generally, you must pay all costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	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 <a href="#">deductible</a> amount. A <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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 <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$8,700 individual / \$17,400 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> , they must meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> is met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges and health care this <a href="#">plan</a> doesn't cover.	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/find-doctor">www.denverhealthmedicalplan.org/find-doctor</a> or call 1-855-823-8872 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You pay less when using a <a href="#">provider</a> in the plan's <a href="#">network</a> . You pay more if you use an <a href="#">out-of-network provider</a> , and you may receive a bill from a <a href="#">provider</a> for the difference of the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Your <a href="#">network provider</a> may use an <a href="#">out-of-network provider</a> for some services. Check with your <a href="#">provider</a> 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$0 copay/visit	100% <a href="#">coinsurance</a>	[-----none-----]
	<a href="#">Specialist</a> visit	\$50 copay/visit	100% <a href="#">coinsurance</a>	[-----none-----]
	Other practitioner office visit	\$50 copay for chiropractor	100% <a href="#">coinsurance</a>	Care must be received by a Columbine Chiropractic provider. Coverage is limited to 20 visits annually.
	<a href="#">Preventive care/screening/immunization</a>	No charge	100% <a href="#">coinsurance</a>	-----none-----
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% coinsurance after deductible/test	100% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible/test	100% <a href="#">coinsurance</a>	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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="https://www.denverhealthmedicalplan.org/elevate-current-members">prescription drug coverage</a> is available at <a href="https://www.denverhealthmedicalplan.org/elevate-current-members">www.denverhealthmedicalplan.org/elevate-current-members</a>	Preventive drugs (Tier 1)	No charge	100% <a href="#">coinsurance</a>	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: \$5 copay 90 Day: \$10 copay Non-Denver Health Pharmacy 30 Day: \$10 copay 90 Day: \$20 copay	100% <a href="#">coinsurance</a>	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 90 Day: \$50 copay Non-Denver Health Pharmacy 30 Day: \$50 copay 90 Day: \$100 copay	100% <a href="#">coinsurance</a>	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: \$100 copay 90 Day: \$200 copay Non-Denver Health Pharmacy 30 Day: \$200 copay 90 Day: \$400 copay	100% <a href="#">coinsurance</a>	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.
	<a href="#">Specialty drugs (Tier 5)</a>	Denver Health Pharmacy: 30 Day: \$300 copay 90 Day: N/A Non-Denver Health Pharmacy 30 Day: \$600 copay 90 Day: N/A	100% <a href="#">coinsurance</a>	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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
	Physician/surgeon fees	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% coinsurance after deductible	30% coinsurance after deductible	-----none-----
	<a href="#">Emergency medical transportation</a>	30% coinsurance after deductible	30% coinsurance after deductible	-----none-----
	<a href="#">Urgent care</a>	\$50 copay	\$50 copay	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
	Physician/surgeon fees	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient Services	No charge for office visits, other outpatient services 30% coinsurance after deductible	100% <a href="#">coinsurance</a>	-----none-----
	Inpatient Services	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If you are pregnant</b>	Office visits	\$0 copay	100% <a href="#">coinsurance</a>	Preventive/prenatal visits and one postnatal visit are a \$0 <a href="#">copay</a> . Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	-----none-----
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Rehabilitation services</a>	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Coverage is limited to 30 visits annually per type of therapy.
	<a href="#">Habilitation services</a>	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Coverage is limited to 30 visits annually per type of therapy.
	<a href="#">Skilled nursing care</a>	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required. Coverage is limited to 100 days per year.
	<a href="#">Durable medical equipment</a>	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	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)	
	<a href="#">Hospice services</a>	30% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	No charge	100% <a href="#">coinsurance</a>	-----none-----
	Children's glasses	No charge	100% <a href="#">coinsurance</a>	Coverage is limited to one pair per 24-month period per child age 18 and under.
	Children's dental check-up	100% <a href="#">coinsurance</a>	100% <a href="#">coinsurance</a>	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](#).)**

- |                            |  |                        |
|----------------------------|--|------------------------|
| • Cosmetic surgery         | • Long-term care                                     | • Routine foot care    |
| • Dental care (Adult)      | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Routine eye care (Adult) |  |                        |

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

- |                     |   |   |
|---------------------|---|---|
| • Bariatric surgery | • Hearing aids  | • Private-duty nursing (when medically necessary) |
| • Chiropractic care | • Infertility treatment                               | • Acupuncture                                     |
| • Abortion services | • 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](http://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](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: Elevate Health Plans at 1-855-823-8872 or [www.denverhealthmedicalplan.org/elevate-current-members](http://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](http://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.*—————



## 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](#): \$1,875
- [Specialist](#) copayment: \$50 copay
- Hospital (facility) coinsurance: 30% 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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,875
Copayments	\$10
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,345</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#): \$1,875
- [Specialist](#) copayment: \$50 copay
- Hospital (facility) coinsurance: 30% 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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#): \$1,875
- [Specialist](#) copayment: \$50 copay
- Hospital (facility) coinsurance: 30% 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)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,875
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,275</b>

(Tagalog) Kung ikaw, o ang iyong tinutulungan, 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.



(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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