

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 Bronze 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 or call 1-855-823-8872 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$7,500 / individual or \$15,000 / 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 \$9,200 individual / \$18,400 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.

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.

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	3 visits at \$0 then \$50 copay after deductible/visit	100% coinsurance	[-----none-----]
	Specialist visit	50% coinsurance after deductible/visit	100% coinsurance	[-----none-----]
	Other practitioner office visit	50% 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)	50% coinsurance after deductible/test	100% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible/test	100% coinsurance	Pre-authorization required.

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.

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 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: \$100 copay 90 Day: \$200 copay Non-Denver Health Pharmacy 30 Day: \$200 copay 90 Day: \$400 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: \$175 copay 90 Day: \$350 copay Non-Denver Health Pharmacy 30 Day: \$350 copay 90 Day: \$700 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: \$350 copay 90 Day: N/A Non-Denver Health Pharmacy 30 Day: \$700 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.

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.

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)	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Physician/surgeon fees	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
If you need immediate medical attention	Emergency room care	50% coinsurance after deductible	50% coinsurance after deductible	-----none-----
	Emergency medical transportation	50% coinsurance after deductible	50% coinsurance after deductible	-----none-----
	Urgent care	50% coinsurance after deductible	50% coinsurance after deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Physician/surgeon fees	50% 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 50% coinsurance after deductible	100% coinsurance	-----none-----
	Inpatient Services	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
If you are pregnant	Office visits	3 visits at \$0 then \$50 copay 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	50% coinsurance after deductible	100% coinsurance	-----none-----
If you need help recovering or have other special health needs	Home health care	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Rehabilitation services	50% coinsurance after deductible	100% coinsurance	Coverage is limited to 30 visits annually per type of therapy.
	Habilitation services	50% coinsurance after deductible	100% coinsurance	Coverage is limited to 30 visits annually per type of therapy.
	Skilled nursing care	50% coinsurance after deductible	100% coinsurance	Pre-authorization required. Coverage is limited to 100 days per year.

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.

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	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Hospice services	50% 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](#).)

- Cosmetic surgery
- Dental care (Adult)
- Routine eye 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
- Abortion services
- Hearing aids
- Infertility treatment
- Transgender hormone therapy and surgical procedures
- Private-duty nursing (when medically necessary)
- 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,

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.

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](#): \$7,500
- [Specialist](#) copayment: 50% coinsurance after deductible
- Hospital (facility) coinsurance: 50% 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	\$7,500
Copayments	\$50
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$9,250

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#): \$7,500
- [Specialist](#) copayment: 50% coinsurance after deductible
- Hospital (facility) coinsurance: 50% 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	\$1,700
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,200

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#): \$7,500
- [Specialist](#) copayment: 50% coinsurance after deductible
- Hospital (facility) coinsurance: 50% 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	\$2,800
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,810

8 of 9

(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.

ددرروومرددللاووس،، ددینکییمکموواا،،امشدرگاالهشادددینشابقحنییاا ارر ددیبرادد سککمووتتاعلاططاا،،بنابززدووخاا ارر،،بررووطننلگیاارر نتفایررد،،(Persian) Denver Health Medical Plan, Inc. ددییامند
ددییامند 8872-823-855-1 سسامت 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.