

## 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 Peak Colorado Option Bronze Off Exchange

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> ?	\$7,500 / individual or \$15,000 / 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> \$9,200 individual / \$18,400 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.

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.

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	3 visits at \$0 then \$50 copay after deductible/visit	100% <a href="#">coinsurance</a>	[-----none-----]
	<a href="#">Specialist</a> visit	50% coinsurance after deductible/visit	100% <a href="#">coinsurance</a>	[-----none-----]
	Other practitioner office visit	50% coinsurance after deductible 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)	50% coinsurance after deductible/test	100% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible/test	100% <a href="#">coinsurance</a>	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.

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: \$15 copay 90 Day: \$30 copay Non-Denver Health Pharmacy 30 Day: \$30 copay 90 Day: \$60 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: \$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.
	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% <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: \$350 copay 90 Day: N/A Non-Denver Health Pharmacy 30 Day: \$700 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.

**Questions:** Call 1-855-823-8872 or visit us at [www.denverhealthmedicalplan.org](https://www.denverhealthmedicalplan.org). See the Glossary for underlined items. You can view the Glossary at [www.healthcare.gov/sbc-glossary](https://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% <a href="#">coinsurance</a>	Pre-authorization required.
	Physician/surgeon fees	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% coinsurance after deductible	50% coinsurance after deductible	-----none-----
	<a href="#">Emergency medical transportation</a>	50% coinsurance after deductible	50% coinsurance after deductible	-----none-----
	<a href="#">Urgent care</a>	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% <a href="#">coinsurance</a>	Pre-authorization required.
	Physician/surgeon fees	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	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% <a href="#">coinsurance</a>	-----none-----
	Inpatient Services	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
If you are pregnant	Office visits	3 visits at \$0 then \$50 copay after deductible	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	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	-----none-----
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Rehabilitation services</a>	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Coverage is limited to 30 visits annually per type of therapy.
	<a href="#">Habilitation services</a>	50% 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>	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required. Coverage is limited to 100 days per year.

**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.

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="#">Durable medical equipment</a>	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
	<a href="#">Hospice services</a>	50% coinsurance after deductible	100% <a href="#">coinsurance</a>	Pre-authorization required.
<b>If your child needs dental or eye care</b>	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
- 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](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,

**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.

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).

**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
<b>The total Peg would pay is</b>	<b>\$9,250</b>

### 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
<b>The total Joe would pay is</b>	<b>\$3,200</b>

### 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
<b>The total Mia would pay is</b>	<b>\$2,810</b>

8 of 9



