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



Denver Health Medical Plan, Inc.: Elevate Health Plans Peak Colorado Option Bronze Off Exchange

ALLIANCE

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 <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> 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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of deductible expenses paid by all family members meets the overall family <u>deductible</u> .	
Are there services covered before you meet your <u>deductible?</u>	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 <u>deductible</u> amount. A <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/.	
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.	
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$9,200 individual / \$18,400 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members on this <u>plan</u> , they must meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> is met.	
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See www.denverhealthmedicalplan.org /find-doctor or call 1-855-823-8872 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay less when using a <u>provider</u> in the plan's <u>network</u> . You pay more if you use an <u>out-of-network provider</u> , and you may receive a bill from a <u>provider</u> for the difference of the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Your <u>network provider</u> may use an <u>out-of-network provider</u> for some services. Check with your <u>provider</u> before you get services.	

•	<b>Coverage:</b> What this Plan Covers & What You Pay For Covered Services an, 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

Do you need a <u>referral</u> to see a <u>specialist</u> ?	UBGYN and outpatient mental	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services if you have a <u>referral</u> before you see the <u>specialist</u> .
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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What You Will P	ay	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	3 visits at \$0 then \$50 copay after deductible/visit	100% <u>coinsurance</u>	[]
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	50% coinsurance after deductible/visit	100% <u>coinsurance</u>	[]
	Other practitioner office visit	50% coinsurance after deductible for chiropractor	100% <u>coinsurance</u>	Care must be received by a Columbine Chiropractic provider. Coverage is limited to 20 visits annually.
	Preventive care/screening/ immunization	No charge	100% <u>coinsurance</u>	none
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance after deductible/test	100% <u>coinsurance</u>	none
	Imaging (CT/PET scans, MRIs)	50% coinsurance after deductible/test	100% <u>coinsurance</u>	Pre-authorization required.

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		What You Will P	Pay	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.denverhealthmedi calplan.org/elevate- current-members	Preventive drugs (Tier 1)	No charge	100% <u>coinsurance</u>	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% <u>coinsurance</u>	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% <u>coinsurance</u>	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% <u>coinsurance</u>	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% <u>coinsurance</u>	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	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required.
surgery	Physician/surgeon fees	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required.
	Emergency room care	50% coinsurance after deductible	50% coinsurance after deductible	none
If you need immediate medical attention	Emergency medical transportation	50% coinsurance after deductible	50% coinsurance after deductible	none
	<u>Urgent care</u>	50% coinsurance after deductible	50% coinsurance after deductible	none
lf you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required.
	Physician/surgeon fees	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required.
If you need mental health, behavioral health, or substance	Outpatient Services	No charge for office visits, other outpatient services 50% coinsurance after deductible	100% <u>coinsurance</u>	none
abuse services	Inpatient Services	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required.
lf you are pregnant	Office visits	3 visits at \$0 then \$50 copay after deductible	100% <u>coinsurance</u>	Preventive/prenatal visits and one postnatal visit are a \$0 <u>copay</u> . Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	50% coinsurance after deductible	100% <u>coinsurance</u>	none
	Home health care	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required.
lf you need help recovering or have	Rehabilitation services	50% coinsurance after deductible	100% <u>coinsurance</u>	Coverage is limited to 30 visits annually per type of therapy.
other special health needs	Habilitation services	50% coinsurance after deductible	100% <u>coinsurance</u>	Coverage is limited to 30 visits annually per type of therapy.
10000	Skilled nursing care	50% coinsurance after deductible	100% <u>coinsurance</u>	Pre-authorization required. Coverage is limited to 100 days per year.

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Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Hospice services	50% coinsurance after deductible	100% coinsurance	Pre-authorization required.
	Children's eye exam	No charge	100% coinsurance	none
If your child needs	Children's glasses	No charge	100% <u>coinsurance</u>	Coverage is limited to one pair per 24-month period per child age 18 and under.
dental or eye care	Children's dental check-up	100% <u>coinsurance</u>	100% <u>coinsurance</u>	Only dental coverage is fluoride varnish at PCP visit.

Excluded Services & Other Covered S		
	OT Cover (Check your policy or plan document for more information	
Cosmetic surgery	Long-term care	Routine foot care
<ul> <li>Dental care (Adult)</li> </ul>	<ul> <li>Non-emergency care when traveling outside the</li> </ul>	<ul> <li>Weight loss programs</li> </ul>
Routine eye care (Adult)	U.S.	
· · · · · · · · · · · · · · · · · · ·	nay apply to these services. This isn't a complete list. Please see	· · ·
Bariatric surgery	Hearing aids	• Private-duty nursing (when medically necessary)
Chiropractic care	<ul><li>Infertility treatment</li><li>Transgender hormone therapy and surgical</li></ul>	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 <a href="http://www.doi.gov/agencies/ebsa">www.doi.gov/agencies/ebsa</a>, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="http://www.HealthCare.gov">Marketplace</a>. For more information about the <a href="http://www.HealthCare.gov">Marketplace</a>, visit <a href="http://www.HealthCare.gov">www.HealthCare.gov</a> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance,

contact: Elevate Health Plans at 1-855-823-8872 or <u>www.denverhealthmedicalplan.org/elevate-current-members</u>, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/agencies/ebsa</u>.

# Does this plan provide Minimum Essential Coverage? Yes

If you don't have <u>Minimum Essential Coverage</u> 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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

——To see examples of how this plan might cover costs for a sample medical situation, see the next section.—



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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

#### 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			

\$12,700

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

- The plan's overall <u>deductible</u>: \$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 <u>deductible</u>: \$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)

#### 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		

# 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. ጥያቄካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ *ጋ*ር ለመነ*ጋ*ገር፣ 1-855-823-8872 ይደውሉ**።** 

صصوو صخبة لئسأا مددعاسة صصخشى يداوو أأكك بيددان كالمراح الما الما الما المعاد الما الما الما الما معدد عاسة صصخ

.8872-823-8872 بـ النصلل

(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 तपाई आफ्ना लागि आफैं आवेदनको काम गर्दें, वत्र कहैलाई मद्दत गर्दे हुनुहुन्छ, Denver Health Medical Plan, Inc.

बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा निःशुल्क सहायता वा जानकारी पाउने अधिकार छ । दोभाषे (इन्टरपरे्टर) सँग कुरा गनरुपरे 🗍 855 823 8872 🦷 मा फोन गर्नुहरेसु ।

(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.

دديريومرر ددللااووسر, ديبينكبيمكمكووا لمعبامشه ممكى سكابير,امشرر گالمعتشاادد ديبيشابق حننيباا اارر ديبيرر اادد ممككمكوو تت اعلاططاا لمعبن ابزز ديوو خاارر معبررووططن ناكمبياارر نتفابيريد . يديبيامذ 1-823-839-283-839 سرسامة لل صاح

(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.