





**Coverage Period: 1/1/2027-12/31/2027**

**Denver Health Medical Plan, Inc.: Elevate Health Plans Peak Colorado Option Gold** **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?** | $2,400 / individual or $4,800 / 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 $10,450 individual / $20,900 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 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. |

| | | |
|---|---|---|
| **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 | No charge, deductible does not apply | 100% coinsurance | [----------none----------] |
| | Specialist visit | $55 copay, deductible does not apply | 100% coinsurance | [----------none----------] |
| | Other practitioner office visit | $55 copay, deductible does not apply | 100% coinsurance | Care must be received by a Columbine Chiropractic provider. Coverage is limited to 20 visits annually. |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | 100% coinsurance | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance after deductible/test | 100% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 30% 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, deductible does not apply | 100% coinsurance | Preventive Care medications are provided with no cost-sharing, regardless of tier.<br>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:<br>30 Day: $5 copay, deductible does not apply<br>90 Day: $10 copay, deductible does not apply<br>Non-Denver Health Pharmacy<br>30 Day: $10 copay, deductible does not apply<br>90 Day: $20 copay, deductible does not apply | 100% coinsurance | Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).<br>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:<br>30 Day: $25 copay, deductible does not apply<br>90 Day: $50 copay, deductible does not apply<br>Non-Denver Health Pharmacy<br>30 Day: $50 copay, deductible does not apply<br>90 Day: $100 copay, deductible does not apply | 100% coinsurance | Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).<br>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. |

| 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) | |
| | Non-preferred brand/Preferred Specialty drugs (Tier 4) | Denver Health Pharmacy:<br>30 Day: $100 copay, deductible does not apply<br>90 Day: $200 copay, deductible does not apply<br>Non-Denver Health Pharmacy<br>30 Day: $200 copay, deductible does not apply<br>90 Day: $400 copay, deductible does not apply | 100% coinsurance | Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).<br>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:<br>30 Day: $300 copay, deductible does not apply<br>90 Day: N/A<br>Non-Denver Health Pharmacy<br>30 Day: $600 copay, deductible does not apply<br>90 Day: N/A | 100% coinsurance | Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription).<br>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. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Physician/surgeon fees | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance after deductible | 30% coinsurance after deductible | ----------none---------- |
| | Emergency medical transportation | 30% coinsurance after deductible | 30% coinsurance after deductible | ----------none---------- |
| | Urgent care | $50 copay, deductible does not apply | $50 copay, deductible does not apply | ----------none---------- |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Physician/surgeon fees | 30% 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, unlimited, deductible does not apply; other outpatient services 30% coinsurance after deductible | 100% coinsurance | ----------none---------- |
| | Inpatient Services | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| **If you are pregnant** | Office visits | No charge, unlimited, deductible does not apply | 100% coinsurance | ----------none---------- |
| | Childbirth/delivery professional/facility services | 30% coinsurance after deductible | 100% coinsurance | ----------none---------- |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Rehabilitation services | 30% coinsurance after deductible | 100% coinsurance | Coverage is limited to 30 visits annually per type of therapy. |
| | Habilitation services | 30% coinsurance after deductible | 100% coinsurance | Coverage is limited to 30 visits annually per type of therapy. |
| | Skilled nursing care | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. Coverage is limited to 100 days per year. |
| | Durable medical equipment | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| | Hospice services | 30% coinsurance after deductible | 100% coinsurance | Pre-authorization required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | 100% coinsurance | ----------none---------- |
| | Children's glasses | No charge, deductible does not apply | 100% coinsurance | Coverage is limited to one pair per 24-month period per child age 18 and under, up to $120. |
| | Children's dental check-up | Not Covered | 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, contact: Elevate Health Plans at 1-855-823-8872 or 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:** $2,400
- **Specialist copayment:** $55 copay, deductible does not apply
- **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)

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,400 |
| Copayments | $10 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,770** |

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

- **The plan's overall deductible:** $2,400
- **Specialist copayment:** $55 copay, deductible does not apply
- **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)

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Copayments | $1,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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:** $2,400
- **Specialist copayment:** $55 copay, deductible does not apply
- **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)

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,400 |
| Copayments | $200 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,350** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## Notice of Availability:

**English:** ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-700-8140 (TTY 711) or speak to your provider.

**Spanish/Español:** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen sin costo herramientas y servicios auxiliares adecuados para brindar información en formatos accesibles. Llame al 1-800-700-8140 (TTY 711) o hable con su proveedor.

**Chinese Mandarin/简体中文：**注意：如果您使用简体中文，可免费获得语言协助服务，也可免费获得适当的辅助设备和服务，

获取无障碍格式的信息。请拨打 1-800-700-8140 (TTY 711) 或联系您的提供者。

**Chinese Cantonese/繁體中文：**注意：如果您使用繁體中文，可免費獲得語言協助服務，也可免費獲得適當的輔助設備和服務，

獲取無障礙格式的資訊。請撥打 1-800-700-8140 (TTY 711) 或聯絡您的提供者。

**Tagalog/Paalala:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-700-8140 (TTY 711) o makipag-usap sa iyong provider.

**French/Français:** INFORMATION : Si vous parlez Français, des services gratuits d'assistance linguistique vous sont proposés. Des aides et des services auxiliaires adaptés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-700-8140 (TTY 711) ou parlez-en à votre prestataire.

**Vietnamese/Việt:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-700-8140 (Người khuyết tật 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

**German/Deutsch:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Außerdem können Sie kostenfrei entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten in Anspruch nehmen. Rufen Sie 1-800-700-8140 (TTY 711) an oder sprechen Sie mit Ihrem Anbieter.

**Korean/한국어:** 주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-700-8140 (TTY 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Russian/РУССКИЙ:** ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-700-8140 (TTY 711) или обратитесь к своему поставщику услуг.

**Hindi/ हिंदी :** ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-700-8140 (TTY 711) पर कॉल करें या अपने प्रदाता से बात करें।.

**Polish/Polski:** UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-700-8140 (TTY 711) lub porozmawiaj ze swoim dostawcą.

**Arabic:العربية:**

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-800-700-8140 (TTY 711) أو تحدث إلى مقدم الخدمة".

**Italian/Italiano:** ATTENZIONE: Se parla italiano, sono disponibili servizi gratuiti di assistenza linguistica. Sono inoltre disponibili supporti adeguati e servizi gratuiti per fornire informazioni in formati accessibili. Chiami 1-800-700-8140 (TTY 711) o consulti il suo fornitore di servizi.

**Portuguese/Português:** ATENÇÃO: Se fala português, são-lhe disponibilizados serviços de assistência linguística sem custos. São também disponibilizados, sem custos, aparelhos e serviços auxiliares adequados para prestar informações em formatos acessíveis. Ligue 1-800-700-8140 (TTY 711) ou fale com o seu prestador de serviços.

**French Creole/Kreyòl Ayisyen**: ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lengwistik yo disponib pou ou sou sit sa. Èd ak

sèvis oksilyè adapte yo ki ap pèmèt ou resevwa enfòmasyon yo nan fòma aksesib yo, yo founi yo tou gratis. Pou jwenn sèvis sa, rele 1-800-700-8140 (TTY 711) oswa kontakte founisè ou an.

**Japanese/日本語:**

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-700-8140（TTY711）までお電話ください。または、ご利用の事業者にご相談ください。