Elevate Medicare Advantage

Elevate Medicare Choice (HMO D-SNP)

Adams, Denver or Jefferson County

Summary of Benefits

2023

January 1-December 31, 2023

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About this Summary of Benefits

Thank you for considering Elevate Medicare Advantage by Elevate Medicare Advantage. You can use this **Summary of Benefits** to learn more about our plan. It includes information about:

- Premiums
- Benefits and costs
- Part D prescription drugs
- Who can enroll
- Coverage rules
- Getting care
- Summary of Medicaid covered benefits

For more details

This document is a summary. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which is located on our website at www.denverhealthmedicalplan.org or ask for a copy from Health Plan Services by calling 303-602-2111 or toll free 1-877-956-2111. TTY should call 711. Our hours of operation are 8 a.m. to 8 p.m., seven days a week.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-of-network/non-contracted providers are under no obligation to treat Elevate Medicare Choice (HMO D-SNP) members, except in emergency situations. Please call our Health Plan Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Elevate Medicare Advantage is a Medicare-approved HMO plan. Elevate Medicare Advantage depends on contract renewal. The plan also has a written agreement with Health First Colorado – Colorado's Medicaid Program to coordinate your Medicaid benefits.

ATTENTION: If you speak Spanish, language assistance services are available to you at no cost. Please call our Health Plan Services at 303-602-2111 or toll free 1-877-956-2111. TTY should call 711. Our hours of operation are 8 a.m. to 8 p.m., seven days a week.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a nuestros Servicios del Plan de Salud al 303-602-2111 o sin costo al 1-877-956-2111. Los usuarios de TTY deben llamar al 711. Nuestro horario de atención es de 8 a.m. a 8 p.m., los siete días de la semana.

Who Can Enroll?

Elevate Medicare Choice (HMO D-SNP) is a dual special needs plan, a Medicare Advantage plan available exclusively to beneficiaries eligible for both Medicare and Medicaid. You are eligible to enroll for this plan if:

- You have both Medicare Part A and Part B.
- You are entitled to Medicare Part D.
- You have Qualified Medicare Beneficiary (QMB) or full Medicaid benefits.
- You reside in Adams, Denver or Jefferson County.

What Do We Cover?

- Our plan members get the same benefits covered by Original Medicare and more. Some of the benefits are outlined in this document. For a full list of benefits, you can access our **EOC** online.
- You are covered by both Medicare and QMB or Medicaid. Medicare covers health care and prescription drugs. QMB and Medicaid cover your cost-sharing for Medicare services, including copays and coinsurance. You do not pay anything for these services listed in the Benefits Chart, as long as you remain eligible for both Medicare and QMB or Medicaid.
- We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

Coverage Rules

We cover the services and items listed in this document and the **EOC**, if:

- The services or items are medically necessary.
- The services or items are considered reasonable and necessary according to Original Medicare's standards.
- You get all covered services and items from the plan providers listed in our Provider Directory and Pharmacy Directory (there are exceptions to this rule). We also cover:
    - Emergency Care
    - Urgent Care
    - Out-of-Area Dialysis

For details about coverage rules, including services that are not covered (exclusions), see the **EOC**.

Getting Care

At most of our in-network facilities, you can usually get the covered services you need, including specialty care, pharmacy and lab work. To find our provider locations, see our Provider Directory online (www.denverhealthmedicalplan.org) or ask us to mail you a copy by calling Health Plan Services at 303-602-2111 or toll free 1-877-956-2111. TTY should call 711. Our hours of operation are 8 a.m. to 8 p.m., seven days a week.

Medicare Part C: What's covered and what it costs

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	
Monthly Plan Premiums	$0 - $41.60** per month, depending on your level of *Extra Help.*
Deductible	The deductible is $0** or $226 and applies to in-network services. The Part D deductible is $0** or $505, and applies to prescription drugs.
Your Maximum Out-of-Pocket Responsibility Does not include Medicare Part D drugs. If you are eligible for Medicare cost-sharing assistance under QMB or Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Medicare Part A and Part B services.	$8,200**
Inpatient Hospital Coverage*† Our plan covers 90 days per benefit period.	$0** or $1,600 deductible for each benefit period. • Days 1-60: $0 copay per day for each benefit period • Days 61-90: $400 copay per day for each benefit period • Days 91 and beyond: $800 copay per day for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs †Prior authorization is required for all acute rehabilitation services.

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	
Outpatient Hospital Coverage*	$0** or 20% of the total cost after the deductible is met.
Ambulatory Surgical Center*	$0** or 20% of the total cost after the deductible is met.
Doctor Office Visits*	Primary Care Visit: $0** or 20% of the total cost after the deductible is met. Specialist Visit*: $0** or 20% of the total cost after the deductible is met.
Preventive Care	$0 copay. *See **EOC** for details.*
Emergency Care Emergency care is not covered outside the United States.	$0** or 20% of the total cost (up to $95) for Medicare-covered emergency room visits. If you are admitted to the hospital within 3 days you pay $0 for the emergency room visit.
Urgently Needed Services Urgent care is not covered outside the United States.	$0** or 20% of the total cost (up to $60) for each Medicare-covered urgent care visit. If you are admitted to the hospital within 3 days, you pay $0 for the urgent care visit.
Diagnostic Services, Lab and Imaging* • Diagnostic tests and procedures • X-rays • Lab tests	$0** or 20% of the total cost after the deductible is met for Medicare-covered diagnostic tests, procedures and x-rays.
Hearing Services • Exam to diagnose and treat hearing and balance issues • Routine hearing exams • Hearing aid fitting or evaluation exam • Hearing aids	$0** or 20% of the total cost for Medicare-covered diagnostic hearing exams. $0 copay for up to one supplemental routine hearing exam every three years. $0 copay for fittings/evaluations for hearing aids. Covered up to $1,500 for supplemental hearing aids (both ears combined) every three years.
Dental Services† Preventive and comprehensive dental coverage	$3,000 annual maximum benefit for preventive and comprehensive dental services every year. $0 copay for limited dental services, subject to Delta Dental processing policies, limitations and exclusions. • Cleanings (up to 2 per calendar year) • Bitewing x-ray (1 set of 4 per calendar year)

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	
	• Full mouth or panoramic x-ray (1 every 60 months) • Fluoride treatment (one treatment per year) • Fillings (up to 1 per tooth per 12 months. Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed) *See **EOC** for details.*
Vision Services • Visits to diagnose and treat eye disease and conditions • Supplemental routine eye exam • Contact lenses and/or eyeglasses (frames and lenses)	$0** or 20% of the total cost for Medicare-covered diagnosis and treatment for diseases and conditions of the eye. $0** or 20% of the total cost for annual glaucoma screening for people at risk. $0 copay for up to one routine eye exam every year. You are covered up to $250 for contact lenses and/or unlimited eyeglasses (lenses and frames) every year.
Inpatient Services in a Psychiatric Hospital*† Our plan covers up to 90 days for each benefit period and up to 60 days over your lifetime for inpatient mental health care in a psychiatric hospital.	$0** or $1,600 deductible for each benefit period. • Days 1-60: $0 copay per day for each benefit period • Days 61-90: $400 copay per day for each benefit period • Days 91 and beyond: $800 copay per day for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs
Outpatient Mental Health Services* Outpatient group and individual therapy	$0** or 20% of the total cost after the deductible is met.
Skilled Nursing Facility (SNF)* Our plan covers up to 100 days per benefit period. A new benefit period begins after 60 days with no readmission for the same condition.	$0** or: • Days 1 – 20: $0 copay per day for each benefit period • Days 21 – 100: $0** or $200 copay per day for each benefit period • Days 101 and beyond: All costs
Outpatient Rehabilitation* • Cardiac (Heart) • Pulmonary (Lung) • Occupational Therapy†	$0** or 20% of the total cost after the deductible is met. †Prior authorization is required starting with the 31st visit for occupational, physical and speech therapy services.

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	
• Physical Therapy† • Speech Therapy†	
Ambulance†	$0** or 20% of the total cost after the deductible is met. If you are admitted to the hospital, you do not have to pay your share of the cost for the ambulance services. †Prior authorization is required for non-emergency Medicare-covered services and air ambulance.
Transportation Round-trip non-emergent medical transportation to plan approved health-related locations.	$0 copay for unlimited round trips to plan-approved locations through Access2Care.
Medicare Part B Drugs †for non-preferred Part B drugs	$0** or 20% of the total cost after the deductible is met. Effective 4/1/2023, certain rebatable drugs may be subject to a lower coinsurance. Effective 7/1/2023, you will not pay more than $35 for a one-month supply of insulin furnished through an item of DME, even if you have not paid your deductible.

Medicare Part D: Prescription Drug Coverage

Individuals who are entitled to Medicaid benefits also get *Extra Help* from Medicare to pay for their prescription drug plan costs. Medicare provides *Extra Help* to help pay prescriptions for beneficiaries who have limited income and resources.

Initial Coverage Stage

For generic drugs (including brand drugs treated as generic), either:

$0 copay; or
$1.45 copay; or
$4.15 copay; or
15% of the total cost.

For all other drugs, either:

$0 copay; or
$4.30 copay; or

$10.35 copay; or
15% of the total cost**Coverage Gap Stage**

The coverage gap stage is a temporary change in the cost for your prescription drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,660.

After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $7,400, which is the end of the coverage gap.

Not everyone will enter the coverage gap stage. For more information call us at 303-602-2111 or toll free 1-877-956-2111, call 711 for TTY users, or you can access our **EOC** online.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and/or mail-order) reach $7,400, you pay the greater of:

- 5% of the cost; or
- $4.15 for generic (including brand drugs treated as generic) and a $10.35 for all other drugs.

For more information, call us at 303-602-2111 or toll free 1-877-956-2111, call 711 for TTY users, or you can access our **EOC** online.

As a member of DHMP, you may get your drugs any of the following ways:

- **Retail Pharmacy**
  You can get a 30, 60, 90 or 100-day supply of most medications. See the formulary at www.denverhealthmedicalplan.org for details. For less than a month supply, please contact us at 303-602-2111.
- **Long Term Care (LTC) Pharmacy**
  LTC pharmacies must dispense brand name drugs in less than a 14-day supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact us at 303-602-2111 or toll free 1-877-956-2111 if you have any questions about cost-sharing or billing when less than a one-month supply is dispensed.
- **Mail Order**
  Contact Health Plan Services at 303-602-2111 or toll free 1-877-956-2111 if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

The plan uses a formulary, you can see the formulary at www.denverhealthmedicalplan.org, or call Health Plan Services at 303-602-2111 or toll free 1-877-956-2111 for a copy.

Additional Benefits	
Benefits	**You Pay**
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	
Blood Pressure Cuff† This benefit is part of a special supplemental program for the chronically ill. Not all members qualify.	One blood pressure cuff covered up to $135 per lifetime for qualified members. *See **EOC** for eligibility details*.
Chiropractic Care	$0** or 20% of the total cost after the deductible is met. We cover only manual manipulation of the spine to correct subluxation.
Diabetes Supplies and Services†	$0** or 20% of the total cost after the deductible is met for therapeutic shoes, inserts, diabetic monitoring supplies, and diabetes self-management training. †Trividia Health diabetic testing supplies and Freestyle Libre continuous glucose monitoring system do not require authorization. All other vendors require prior authorization.
Elevate Healthy Food Card This benefit is part of a special supplemental program for the chronically ill. Not all members qualify.	$260 quarterly allowance to buy healthy foods on a pre-paid card at participating retailers. Your allowance is available every quarter starting January, April, July and October. The unused quarterly allowance will not carry over. No reimbursements. *See **EOC** for eligibility details*.
Meal Benefit Meals are offered for each Inpatient or Skilled Nursing Facility (SNF) admission (after discharge).	$0 copay for up to 21 meals within 10 days after discharge from each inpatient or SNF admission.
Over-the-Counter (OTC) Mail Order	Covered up to $260 quarterly. Your allowance is available every quarter, starting January, April, July and October. The unused quarterly allowance will not carry over. You can view the catalogue and form at www.denverhealthmedicalplan.org/elevate-medicare-OTC. To order your product(s), mail or fax in the order form found on our web page. No returns, refunds or reimbursements accepted.

Summary of Medicaid-Covered Benefits

The benefits listed below are covered by Medicare. For each benefit listed, you can see what Medicaid covers and what our plan covers. If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Health First Colorado – Colorado's Medicaid Program at 1-800-221-3943. TTY users should call 711.

For more information such as limits, exclusions, and prior authorization rules under fee-for-service Medicaid, you can review the full list at www.healthfirstcolorado.com/benefits-services.

There may be additional copay exclusions for children under the age of 19 and pregnant women. If this may apply to you, you can review the full list of benefits at www.healthfirstcolorado.com/benefits-services.

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Ambulance†	$0 copay.	$0** or 20% of the total cost after the deductible is met. If you are admitted to the hospital, you do not have to pay for the ambulance services. †Prior authorization is only required for non-emergency Medicare-covered services and air ambulance.
Colorectal Cancer Screening	$0 copay under Elevate Medicaid Choice. $2 copay per visit for diagnostic or treatment colonoscopy under Medicaid fee-for-service. $0 copay for screening under Medicaid fee-for-service.	$0 copay.

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Dental Services	$0 copay for cleanings, fillings, root canals, crowns and partial dentures. Adult dental benefit has an annual limit of $1,500 per state fiscal year (July 1st – June 30th). Emergency and denture benefits are not subject to this limit.	$3,000 annual maximum benefit for preventive and comprehensive dental services every year. $0 copay for limited dental services subject to Delta Dental processing policies, limitations, and exclusions. • Cleanings (up to 2 per calendar year) • Bitewing x-ray (1 set of 4 per calendar year) • Full mouth or panoramic x-ray (1 every 60 months) • Fluoride treatment (one treatment per year) • †Fillings (up to 1 per tooth per 12 months. Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed) *See **EOC** for details.*

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Diabetes Supplies and Services† • Diabetes therapeutic shoes or inserts • Diabetic supplies • Diabetes self-management training	$0 copay under Elevate Medicaid Choice. $1 copay per visit under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met for therapeutic shoes or inserts, diabetic monitoring supplies, and diabetes self-management training. †Trividia Health diabetic testing supplies and Freestyle Libre continuous glucose monitoring system do not require authorization. All other vendors require prior authorization.
Diagnostic Tests, Lab Services and Radiology Services*	$0 copay under Elevate Medicaid Choice. $1 copay per visit under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met.
Durable Medical Equipment (DME)† Including oxygen	$0 copay under Elevate Medicaid Choice. $1 copay per day for some DME under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met. †Prior authorization required for all DME and prosthetics with a purchase price of $500 or greater. †Prior authorization required for all DME rental.
Emergency Care	$0 copay under Elevate Medicaid Choice, if determined an emergency. $8 copay per visit if not an emergency under Medicaid fee-for-service.	$0** or 20% of the total cost (up to $95). If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care.

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Hearing Services • Exam to diagnose and treat hearing and balance issues • Routine hearing exams • Hearing aid fitting or evaluation exam • Hearing aids	$0 copay under Elevate Medicaid Choice. $0 copay per visit for Medicaid fee-for-service. Replacement of current cochlear implant if broken/lost.	$0** or 20% of the total cost for Medicare-covered diagnostic hearing exams. $0 copay for up to one supplemental routine hearing exam every three years. $0 copay for fittings/evaluations for hearing aids. You are covered up to $1,500 for supplemental hearing aids (both ears combined) every three years.
Home Health Care*†	$0 copay.	$0 copay.
Hospice	$0 copay. No more than 9 months.	Covered by Original Medicare.
Immunizations	$0 copay.	$0 copay.
Inpatient Hospital Coverage*† Includes substance abuse and rehabilitation	$10 copay per covered day or 50% of the average allowable daily rate, whichever is less under Medicaid fee-for-service.	$0** or $1,600 deductible for each benefit period. • Days 1-60: $0 copay per day for each benefit period • Days 61-90: $400 copay per day for each benefit period • Days 91 and beyond: $800 copay per day for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Inpatient Hospital Coverage*† (Continued)		†Prior authorization is required for all acute rehabilitation services.
Inpatient Services in a Psychiatric Hospital*†	$0 copay.	$0** or $1,600 deductible for each benefit. • Days 1-60: $0 copay per day for each benefit period • Days 61-90: $400 copay per day for each benefit period • Days 91 and beyond: $800 copay per day for each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs
Mammograms	$0 copay.	$0 copay.
Outpatient Mental Health*	$0 copay.†	$0** or 20% of the total cost after the deductible is met.
Outpatient Rehabilitation* • Cardiac (Heart) • Pulmonary (Lung) • Physical Therapy† • Occupational Therapy† • Speech Therapy†	$0 copay under Elevate Medicaid Choice. $4 copay for outpatient hospital visits under Medicaid fee-for-service. $2 copay for physician visits under Medicaid fee-for-service. $0 copay in therapy clinic of rehab agency under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met. †Prior authorization is required starting with the 31st visit for occupational, physical and speech therapy services.

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Outpatient Services/Surgery*	$0 copay under Elevate Medicaid Choice. $4 copay per visit under Medicaid fee-for-service. $0 copay at an ambulatory surgery center under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met.
Outpatient Substance Abuse*	$0 copay.	$0** or 20% of the total cost after the deductible is met.
Pap Smears	$0 copay.	$0 copay.
Podiatry Services*	$0 copay under Elevate Medicaid Choice. $2 copay per visit under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met.
Prescription Drugs†	Medicaid benefits cover the following Medicare exclusions at 100%: Cough and Cold Products, Over-the-Counter Medications, and certain allowed Prescription Vitamin and Mineral Products. $0 copay under Elevate Medicaid Choice.	$505 deductible. Depending on your level of Extra Help, during the Initial Coverage Stage: You pay $0 - $4.15 copay or 15% of the total cost for generic drugs (including brand drugs treated as generic), or You pay $0 - $10.35 copay or 15% of the total cost for all other prescription drugs.
Preventive Care	$0 copay.	$0 copay.

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Primary Care	$0 copay under Elevate Medicaid Choice. $2 copay per visit under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met.
Prostate Cancer Screening Exams	$0 copay.	$0 copay.
Prosthetic Devices†	$0 copay under Elevate Medicaid Choice. $1 copay per visit under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met. †Prior authorization required for all DME and prosthetics with a purchase price of $500 or greater.
Renal Dialysis*	$0 copay under Elevate Medicaid Choice.	$0** or 20% of the total cost after the deductible is met.
Skilled Nursing Facility (SNF)*	$0 copay.	You pay $0** or: • Days 1 – 20: $0 copay per day for each benefit period • Days 21 – 100: $0** or $200 copay per day for each benefit period • Days 101 and beyond: All costs
Specialty Care*	$0 copay under Elevate Medicaid Choice. $2 copay per visit under Medicaid fee-for-service.	$0** or 20% of the total cost after the deductible is met.
Transportation	$0 copay.	$0 copay for round-trip non-emergent medical transportation to plan approved health-related locations through Access2Care.

Benefit Category	Medicaid	Elevate Medicare Choice (HMO D-SNP)
* Referral required. † Your provider must obtain prior authorization from our plan. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Urgently Needed Services	$0 copay under Elevate Medicaid Choice, if determined an emergency. $2 copay per visit if not part of an emergency room under Medicaid fee-for-service.	$0** or 20% of the total cost (up to $60). If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care.
Vision Services	$0 copay under Elevate Medicaid Choice. $2 copay per visit for Medicaid fee-for-service.	$0 copay for up to one routine eye exam every year. $0** or 20% of the total cost for Medicare-covered diagnosis and treatment for diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Covered up to $250 for contact lenses and/or unlimited eyeglasses (lenses and frames) every year.
X-Rays*	$0 copay under Elevate Medicaid Choice. $1 copay per visit under Medicaid fee-for-service. Dental x-rays do not have a co-pay.	$0** or 20% of the total cost after the deductible is met.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Health Plan Services for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-956-2111. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-956-2111. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-956-2111。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-956-2111。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-956-2111. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-956-2111. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-956-2111 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-956-2111. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-956-2111 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-956-2111. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-956-2111. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-956-2111.

पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-956-2111.

Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-956-2111.Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-956-2111. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-956-2111. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-956-2111. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。