



Elevate Medicare Choice (HMO D-SNP) offered by Elevate Medicare Advantage by Denver Health Medical Plan, Inc. (DHMP)

Annual Notice of Changes for 2024

You are currently enrolled as a member of Elevate Medicare Choice (HMO D-SNP). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at DenverHealthMedicalPlan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

- Check the changes to our benefits and costs to see if they affect you.
 - Review the changes to Medical care costs (doctor, hospital).
 - Review the changes to our drug coverage, including authorization requirements and costs.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2024 “Drug List” to make sure the drugs you currently take are still covered.
- Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.
- Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

- Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.
- Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. CHOOSE: Decide whether you want to change your plan

- If you don't join another plan by December 7, 2023, you will stay in Elevate Medicare Choice (HMO D-SNP).
- To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024**. This will end your enrollment with Elevate Medicare Choice (HMO D-SNP).
- Look in section 2, page 16 to learn more about your choices.
- If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- This document is available for free in Spanish.
- Please contact our Health Plan Services number at 303-602-2111 or toll free 1-877-956-2111 for additional information. (TTY users should call 711.) Hours are 8 a.m. to 8 p.m., seven days a week. This call is free.
- This document may be available in other formats such as braille, large print or audio.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Elevate Medicare Choice (HMO D-SNP)

- Elevate Medicare Advantage is a Medicare-approved HMO plan. Enrollment in Elevate Medicare Advantage depends on contract renewal. The plan also has a written agreement with the Colorado Medicaid program to coordinate your Medicaid benefits.
- When this document says "we," "us," or "our," it means Elevate Medicare Advantage. When it says "plan" or "our plan," it means Elevate Medicare Choice (HMO D-SNP).

Annual Notice of Changes for 2024

Table of Contents

Summary of Important Costs for 2024	4
SECTION 1 Changes to Benefits and Costs for Next Year	7
Section 1.1 – Changes to the Monthly Premium	7
Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount.....	7
Section 1.3 – Changes to the Provider and Pharmacy Networks.....	8
Section 1.4 – Changes to Benefits and Costs for Medical Services	8
Section 1.5 – Changes to Part D Prescription Drug Coverage	13
SECTION 2 Deciding Which Plan to Choose.....	16
Section 2.1 – If you want to stay in Elevate Medicare Choice (HMO D-SNP)	16
Section 2.2 – If you want to change plans	16
SECTION 3 Changing Plans	17
SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid	17
SECTION 5 Questions?.....	18
Section 5.1 – Getting Help from Elevate Medicare Choice (HMO D-SNP)	18
Section 5.2 – Getting Help from Medicare	19
Section 5.3 – Getting Help from Medicaid	19

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Elevate Medicare Choice (HMO D-SNP) in several important areas. **Please note this is only a summary of costs.**

Cost	2023 (this year)	2024 (next year)
<p>* 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. \$0 cost-sharing is based on your continued enrollment in Medicaid or Qualified Medicare Beneficiary (QMB).</p>		
<p>Monthly plan premium ♦ ♦ Your premium may be higher than this amount. See Section 1.1 for details.</p>	\$41.60**	\$0
Deductible	\$226**	\$0
Doctor office visits	<p>Primary care visits: \$0** or 20% of the total cost per visit *Specialist visits: \$0** or 20% of the total cost per visit</p>	<p>Primary care visits: \$0 per visit *Specialist visits: \$0 per visit</p>
Inpatient hospital stays †	<p>*\$0** or \$1,556 for each benefit period.</p> <ul style="list-style-type: none"> • Days 1-60: \$0 per day for each benefit period • Days 61-90: \$389 per day for each benefit period • Days 91 and beyond: \$778 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 	<p>No deductible for each benefit period. \$0</p>

Cost	2023 (this year)	2024 (next year)
<p>* 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. \$0 cost-sharing is based on your continued enrollment in Medicaid or Qualified Medicare Beneficiary (QMB).</p>		
<p>Inpatient hospital stays† (Continued)</p>	<p>*Referral is required for Medicare-covered inpatient hospital stays. †Prior authorization is required for all acute rehabilitation services.</p>	<p>Referral is <u>not</u> required for Medicare-covered inpatient hospital stays. †Prior authorization is required for all acute rehabilitation services.</p>
<p>Part D prescription drug coverage (See Section 1.5 for details.)</p>	<p>Deductible: \$505 except for covered insulin products and most adult Part D vaccines.</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Generic Drugs (including brand drugs treated as generic, either): \$0; or \$1.45; or \$4.15; or 15% of the total cost • For all other drugs, either: \$0; or \$4.30; or \$10.35; or 15% of the total cost 	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Generic Drugs (including brand drugs treated as generic): \$0 • For all other drugs: \$0

Cost	2023 (this year)	2024 (next year)
<p>* 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. \$0 cost-sharing is based on your continued enrollment in Medicaid or Qualified Medicare Beneficiary (QMB).</p>		
<p>Part D prescription drug coverage (Continued)</p>	<p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called coinsurance), or a copayment (\$4.15 for a generic drug or a drug that is treated like a generic, and \$10.35 for all other drugs.) 	<p>Catastrophic Coverage:</p> <ul style="list-style-type: none"> • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.
<p>Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)</p>	<p>\$8,200**</p>	<p>\$8,200 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services</p>

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	\$41.60**	\$0

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	\$8,200**	\$8,200 Once you have paid \$8,200 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at DenverHealthMedicalPlan.org/find-doctor. You may also call Health Plan Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2024 Pharmacy Directory to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact Health Plan Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
* Referral required. † Your provider must obtain prior authorization from our plan. Note: \$0 cost-sharing is based on your continued enrollment in Medicaid or Qualified Medicare Beneficiary (QMB)		
Ambulance Services	† Prior authorization is required for non-emergency Medicare-covered ground transportation services.	Prior authorization is <u>not</u> required for non-emergency Medicare-covered ground transportation services.
Dental Benefits (Extra Benefits offered by DHMP)	You pay \$0 up to the \$3,000 annual maximum benefit for covered preventive and dental services every year. Restricted to PPO Medicare Network.	You pay \$0 up to the \$5,000 annual maximum benefit for covered preventive and dental services every year. Restricted to Medicare Advantage PPO Network.

Cost	2023 (this year)	2024 (next year)
<p>Flex Card: Healthy Food and Over-the-Counter (OTC)</p>	<p>Elevate Healthy Food Card</p> <p>\$260 quarterly allowance to buy healthy foods on a prepaid card at participating retailers per qualified member.</p> <p>Your allowance is available every quarter, starting January, April, July and October. The unused quarterly allowance will not carry over.</p> <p>Over-the-Counter (OTC) Mail Order</p> <p>Covered up to \$260 quarterly.</p>	<p>Flex Card: Healthy Food and Over-the-Counter (OTC)</p> <p>We will provide you with quarterly funds that you can use to help pay for covered healthy food and OTC items on a reloadable card. The healthy food allowance is a special benefit for the chronically ill and not all members qualify. All members qualify for the OTC health and wellness benefit. Unused funds expire at the end of each quarter or upon disenrollment.</p> <p>Healthy Food Allowance</p> <ul style="list-style-type: none"> • A member identified as having one or more chronic illnesses (listed in Chapter 4 Section 2.1 of the EOC), will receive quarterly funds loaded onto your Flex Card for the purchase of eligible healthy foods. • Your allowance is available on your reloadable card at the beginning of each quarter of the plan year (January; April; July and October). • Funds must be used at participating retailers for eligible items only. • \$260 a quarter for Healthy Food

Cost	2023 (this year)	2024 (next year)
<p>Flex Card: Healthy Food and Over-the-Counter (OTC) (Continued)</p>		<p>Over-the-Counter Allowance</p> <ul style="list-style-type: none"> • You will receive quarterly funds loaded onto your Flex card for the purchase of OTC health and wellness products. • Your allowance is available on your reloadable card at the beginning of each quarter of the plan year (January, April, July and October). • \$260 a quarter for Over-the-Counter (OTC) <p>For more information on eligible items or locations, contact our Health Plan Services at 303-602-2111 or 1-877-956-2111 (TTY 711). Our hours of operation are 8 a.m. – 8 p.m., seven days a week.</p>
<p>Home Health Care*†</p>	<p>†Prior authorization is required.</p>	<p>†Prior authorization is required starting with the 31st visit.</p>

Cost	2023 (this year)	2024 (next year)
<p>Inpatient Hospital Care†</p>	<p>For Medicare-covered inpatient hospital stays, you pay:</p> <ul style="list-style-type: none"> • Days 1-60: \$0 per day for each benefit period • Days 61-90: \$389 per day for each benefit period • Days 91 and beyond: \$778 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 <p>*Referral is required for Medicare-covered inpatient hospital stays.</p>	<p>For Medicare-covered inpatient hospital stays, you pay:</p> <p>\$0</p> <p>Referral is <u>not</u> required for Medicare-covered inpatient hospital stays.</p>
<p>Inpatient Services in a Psychiatric Hospital†</p>	<p>For Medicare-covered inpatient mental health stays, you pay:</p> <ul style="list-style-type: none"> • Days 1-60: \$0 per day for each benefit period • Days 61-90: \$389 per day for each benefit period • Days 91 and beyond: \$778 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 <p>*Referral is required for Medicare-covered inpatient mental health stays.</p>	<p>For Medicare-covered inpatient mental health stays, you pay:</p> <p>\$0</p> <p>Referral is <u>not</u> required for Medicare-covered inpatient mental health stays.</p>

Cost	2023 (this year)	2024 (next year)
Medicare Part B Prescription Drugs †	<p>20% of the total cost for Medicare Part B chemotherapy drugs and other Part B drugs.</p> <p>\$0-\$35 for a one-month supply of insulin furnished through an item of durable medical equipment, even if you have not paid your deductible.</p> <p>†Prior authorization is required for non-preferred Part B drugs.</p>	<p>\$0 for Medicare Part B chemotherapy drugs and other Part B drugs.</p> <p>\$0 for Medicare Part B insulin drugs.</p> <p>†Prior authorization is required for non-formulary Part B drugs.</p>
Partial Hospitalization Services †	*Referral is required for Medicare-covered partial hospitalization.	Referral is <u>not</u> required for Medicare-covered partial hospitalization.
Podiatry Services	*Referral is required for podiatry services.	Referral is <u>not</u> required for podiatry services.
Skilled Nursing Facility (SNF) Care	*Referral is required for Medicare-covered SNF stays.	Referral is <u>not</u> required for Medicare-covered SNF stays.
Supervised Exercise Therapy (SET)	*Referral is required for Medicare-covered supervised exercise therapy.	Referral is <u>not</u> required for Medicare-covered supervised exercise therapy.
Vision Care	Up to \$250 for contact lenses and/or eyeglasses (lenses and frames) every year.	Up to \$260 for prescription contact lenses and/or eyeglasses (lenses and frames) every year.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our “Drug List”

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our “Drug List” is provided electronically.

We made changes to our “Drug List,” which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the “Drug List” to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the “Drug List” are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online “Drug List” to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Health Plan Services for more information.

Changes to Prescription Drug Costs

There are four **drug payment stages**. The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
<p>**If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0. \$0 cost-sharing is based on your continued enrollment in Medicaid or Qualified Medicare Beneficiary (QMB)</p>		
<p>Stage 1: Yearly Deductible Stage</p>	<p>Your deductible amount is either \$0** or \$505, depending on the level of “Extra Help” you receive. (Look at the separate insert, the LIS Rider, for your deductible amount.)</p>	<p>Because we have no deductible, this payment stage does not apply to you.</p>

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost.</p> <p>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing.</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Generic Drugs (including brand drugs treated as generic), either: \$0; or \$1.45; or \$4.15; or 15% of the total cost</p>	<p>Your cost for a one-month supply filled at a network pharmacy with standard cost sharing:</p> <p>Generic Drugs (including brand drugs treated as generic): \$0</p>

Stage	2023 (this year)	2024 (next year)
<p>Stage 2: Initial Coverage Stage (Continued)</p> <p>For information about the costs for a long-term supply; at a network pharmacy that offers preferred cost sharing; or for mail-order prescriptions, look in Chapter 6 of your <i>Evidence of Coverage</i>.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>For all other drugs:</p> <p>\$0; or \$4.30; or \$10.35; or 15% of the total cost</p> <hr/> <p>Once your total drug costs have reached \$4,660, you will move to the next stage (the Coverage Gap Stage).</p>	<p>For all other drugs:</p> <p>\$0</p> <hr/> <p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>

Changes to your VBID Part D Benefit

Starting in 2024, Elevate Medicare Choice (HMO D-SNP) is participating in the Value-Based Insurance Design Model (VBID) designed to reduce prescription costs. As a result, you pay \$0 for all Part D drugs, regardless of LIS status.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage.**

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6 in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in Elevate Medicare Choice (HMO D-SNP)

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Elevate Medicare Choice (HMO D-SNP).

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, Elevate Medicare Advantage offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Elevate Medicare Choice (HMO D-SNP).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Elevate Medicare Choice (HMO D-SNP).
- To **change to Original Medicare without a prescription drug plan**, you must either:
 - Send us a written request to disenroll. Contact Health Plan Services if you need more information on how to do so.
 - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Health First Colorado – Colorado’s Medicaid Program, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don’t like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Colorado, the SHIP is called Colorado State Health Insurance Assistance Program.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Colorado State Health Insurance Assistance Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can

call Colorado State Health Insurance Assistance Program at 1-888-696-7213. You can learn more about Colorado State Health Insurance Assistance Program by visiting their website (www.doi.colorado.gov).

For questions about your Health First Colorado – Colorado’s Medicaid Program benefits, contact Health First Colorado – Colorado’s Medicaid Program at 1-800-221-3943 (TTY 711) Monday – Friday, 8 a.m. to 4:30 p.m.; the Member Contact Center is closed for staff meetings on the third Thursday of each month from 2:00 p.m. - 3:30 p.m. and for all state holidays. Ask how joining another plan or returning to Original Medicare affects how you get your Health First Colorado – Colorado’s Medicaid Program coverage.

SECTION 5 Questions?

Section 5.1 – Getting Help from Elevate Medicare Choice (HMO D-SNP)

Questions? We’re here to help. Please call Health Plan Services at 303-602-2111 or toll free 1-877-956-2111. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

Read your 2024 Evidence of Coverage (it has details about next year’s benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Elevate Medicare Choice (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at DenverHealthMedicalPlan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at DenverHealthMedicalPlan.org. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/“Drug List”)*.

Section 5.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (<https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf>) or 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.

Section 5.3 – Getting Help from Medicaid

To get information from Medicaid, you can call Health First Colorado – Colorado's Medicaid Program at 1-800-221-3943. TTY users should call 711.

Form Approved
OMB# 0938-1421

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 quý vị cần thông dịch viên xin gọi 1-877-956-2111 sẽ có nhân viên nói tiếng Việt giúp đỡ quý 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 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-956-2111번으로 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.

Portuguese: 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。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。

Form CMS-10802
(Expires 12/31/25)