ELEVATE MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.

2024 Summary Of Benefits

Elevate Medicare Select (HMO)

H5608-002

January 1, 2024 – December 31, 2024

Need Help?

You may have questions as you read through this document, and that's okay. We're here to help.

Call 1-877-956-2111 (TTY 711)

8 a.m. – 8 p.m., seven days a week.

If you need a complete list of what we cover or any limitations, visit DenverHealthMedicalPlan.org for a copy of the Evidence of Coverage (EOC) or you may call us to request a copy.

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To Join Our Plan, You Must:

- ★ Be eligible for Medicare Parts A and B
- ★ Live in Adams, Arapahoe, Denver, or Jefferson County

Medical: What's Covered and What it Costs

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Monthly Plan Premium You must continue to pay your Medicare Part B premium if you have one.	$0
Deductible	$0
Your Maximum Out-of-Pocket Responsibility Does not include Medicare Part D drugs. If you are eligible for Medicare cost-sharing assistance, you are not responsible for paying any costs toward the maximum out-of-pocket amount for covered Medicare Part A and Part B services.	$4,900
Inpatient Hospital Coverage† Our plan covers 90 days per benefit period. A benefit period begins the day you are admitted as inpatient and ends when you have not received any inpatient care for 60 days in a row.	• Days 1–5: $250 per day • Days 6–90: $0 per day • Days 91–150: $800 per day for each "lifetime reserve day" (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs †Prior authorization is required for all acute rehabilitation services.
Outpatient Hospital Coverage*	$0 for diagnostic colonoscopy/endoscopy $275 for other Medicare-covered surgery services $205 for other Medicare-covered non-surgical services
Ambulatory Surgical Center*	$0 for diagnostic colonoscopy/endoscopy $200 for other Medicare-covered surgical services
Doctor Office Visits	Primary Care Visit: $0 Specialist Visit*: $15 physician specialist visit; $35 for minor surgical procedures in a specialist's office.
Preventive Care	$0

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Emergency Care We cover emergency care anywhere in the United States. If you are admitted to the hospital within 3 days, you pay $0 for the emergency room visit.	$110
Urgently Needed Services We cover urgently needed care anywhere in the United States. If you are admitted to the hospital within 3 days, you pay $0 for the urgent care visit.	$40
Diagnostic Services, Lab and Imaging* • Medicare-covered diagnostic tests and procedures • X-rays • Medicare-covered labs	$0 for covered diagnostic procedures, tests, and lab $35 for X-rays <u>Diagnostic Radiology</u> $35 if performed in an office $160 if performed in an outpatient facility <u>Therapeutic Radiology</u> $35 if performed in an office $60 if performed in an outpatient facility
Hearing Services • Exam to diagnose and treat hearing and balance issues • One routine hearing exam every three years • Hearing aid fitting or evaluation exam • Hearing aids	$0 Covered up to $1,500 for supplemental hearing aids (both ears combined) every three years.
Dental Services (Medicare-Covered) Medicare covers some dental services that are closely related to other covered medical services.	$15 for each Medicare-covered medically-necessary dental service.
Dental Benefits (Extra Benefits offered by DHMP) Preventive and Comprehensive Dental Coverage • Cleanings (up to 2 per calendar year) • Oral exams (up to 2 per calendar year) • Bitewing x-ray (1 set per calendar year) • Fluoride treatment (1 treatment per year) • Fillings (up to 2 services per calendar year)	You pay $0 up to the $2,000 annual maximum benefit for preventive and dental services every year.
Vision Services • Visits to diagnose and treat eye disease and conditions • Supplemental routine eye exam every year • Annual glaucoma screening for people at risk • Contact lenses and/or eyeglasses (frames and lenses)	$0 Up to $380 for prescription contact lenses and/or eyeglasses (lenses and frames) every year.

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Inpatient Services in a Psychiatric Hospital† Our plan covers up to 90 days for each benefit period and up to 190 days over your lifetime for inpatient mental health care in a psychiatric hospital.	• Days 1-5: $250 per day • Days 6-90: $0 per day • Days 91-150: $800 per day for each "lifetime reserve day" (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs
Outpatient Mental Health Services* Outpatient group and individual therapy	$20
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.	• Days 1-20: $0 per day • Days 21-44: $188 per day • Days 45-100: $0 per day • Days 101 and beyond: All costs
Outpatient Rehabilitation* • Cardiac (Heart) • Pulmonary (Lung) • Occupational Therapy† • Physical Therapy† • Speech Therapy†	$20 for each cardiac visit $15 for each pulmonary visit $35 for each occupational therapy visit $25 for each physical and speech therapy visit †Prior authorization is required starting with the 31st visit for occupational, physical and speech therapy services.
Ambulance	$250 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-emergent air ambulance services.
Transportation Unlimited round-trip non-emergent medical transportation to plan approved health-related locations through Access2Care.	$0
Medicare Part B Drugs†	0-20% of the total cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0-20% of the total cost, maximum $35 for Medicare Part B insulin drugs. †Prior authorization is required for non-formulary Part B drugs.

Prescription Drug Coverage

Some individuals may be entitled to *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. If you'd like to learn more or need help applying, call our Sales Department at 303-602-2999.

Initial Coverage Stage

- You pay the following cost sharing as seen in the charts below until your yearly drug costs reach $5,030. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 Preferred Generic drugs	$0	$0	$0
Tier 2 Generic drugs	$9	$18	$18
Tier 3 Preferred Brand drugs	$35 for insulin drugs and $47 for all other drugs on this tier	$70 for insulin drugs and $94 for all other drugs on this tier	$105 for insulin drugs and $141 for all other drugs on this tier
Tier 4 Non-Preferred Brand drugs	$35 for insulin drugs and $95 for all other drugs on this tier	$70 for insulin drugs and $190 for all other drugs on this tier	$105 for insulin drugs and $285 for all other drugs on this tier
Tier 5 Specialty drugs	Up to $35 for insulin drugs and 33% of the total cost for all other drugs on this tier	Not covered	Not covered
Tier 6 Select Care drugs	$0	$0	$0

Standard Mail-Order Cost-Sharing

Tier	One-month supply	Three-month supply
Tier 1 Preferred Generic drugs	Not covered	$0
Tier 2 Generic drugs	Not covered	$0
Tier 3 Preferred Brand drugs	Not covered	$105 for insulin drugs and $141 for all other drugs on this tier
Tier 4 Non-Preferred Brand drugs	Not covered	$105 for insulin drugs and $285 for all other drugs on this tier
Tier 5 Specialty drugs	Up to $35 for insulin drugs and 33% of the total cost for all other drugs on this tier	Not covered
Tier 6 Select Care drugs	Not covered	$0

You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get your drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy**.**

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 $5,030.

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 $8,000, which is the end of the coverage gap.

During this stage, you won't pay more than $35 for a one-month supply of each covered insulin product.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy, mail-order and through home delivery) reach $8,000, the plan pays the full cost for your covered Part D 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 Elevate Medicare Select (HMO), you may get your drugs any of the following ways:

- **Retail Pharmacy**
- **Long Term Care (LTC) Pharmacy**
- **Mail Order**

Costs may differ based on the pharmacy type or status (for example, mail order, LTC, home infusion, and days supply). You can get a 30, 60, 90 or 100-day supply of most medications. See the formulary at DenverHealthMedicalPlan.org. Contact Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 if you have questions about how to fill your prescriptions.

Additional Benefits	
Benefits	**You Pay**
* Referral required. † Your provider must obtain prior authorization from our plan.	
Blood Pressure Monitor This benefit is part of a special supplemental program for the chronically ill. Not all members qualify.	One blood pressure monitor covered up to $135 per lifetime for qualified members participating in the Controlling Blood Pressure Program.
Chiropractic Care We cover only manual manipulation of the spine to correct subluxation.	$20
Denver Parks and Recreation Center Membership We provide an annual membership to the Denver Parks and Recreation Centers. To enroll, take your Elevate Medicare Select (HMO) ID card and a valid photo ID to the recreation center of your choice. Note: this membership does not include the cost to join classes. You may be required to pay a small fee to sign up for fitness classes.	$0
Diabetes Supplies and Services† • therapeutic shoes and inserts • diabetic monitoring supplies • diabetes self-management training	$0 †Trividia Health diabetic testing supplies and Dexcom continuous glucose monitoring system do not require authorization. All other vendors require prior authorization.

Additional Benefits	
Benefits	**You Pay**
* Referral required. † Your provider must obtain prior authorization from our plan.	
Flex Card: Healthy Food and Over-the-Counter (OTC) 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. Healthy Food Allowance • 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. • $75 a quarter for Healthy Food Over-the-Counter Allowance • You will receive a 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). • $75 a quarter for Over-the-Counter (OTC) 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.	Covered up to $600 a year: • $75 a quarter for Healthy Food (for eligible members) • $75 a quarter for Over-the-Counter (OTC) The healthy food benefit is a special benefit for the chronically ill and not all members qualify.

Call Us for Assistance

Call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111. TTY users 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.
Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.
Elevate Medicare Advantage is a Medicare-approved HMO plan. Elevate Medicare Advantage depends on contract renewal.
This document is available in other formats such as Braille, large print, or audio.

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.

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。

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