



## ***Elevate Medicare Choice (HMO D-SNP) offered by Elevate Medicare Advantage***

# **Annual Notice of Change for 2026**

You're enrolled as a member of Elevate Medicare Choice (HMO D-SNP).

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in Elevate Medicare Choice (HMO D-SNP).
- To change to a **different plan**, visit [www.Medicare.gov](http://www.Medicare.gov) or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage*. Get a copy at [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org) or call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) to get a copy by mail.

### **More Resources**

- This material is available for free in Spanish.
- Call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) for more information. Hours are 8 a.m. to 8 p.m., seven days a week. This call is free.
- This information is available in braille, large print or audio.

### **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 Health First Colorado to coordinate your Medicaid benefits.
- When this material 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).
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in** Elevate Medicare Choice (HMO D-SNP). Starting January 1, 2026, you'll get your medical and drug coverage through Elevate Medicare Choice (HMO D-SNP). Go to Section 2 for more information about how to change plans and deadlines for making a change.

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## Table of Contents

|                                                                       |           |
|-----------------------------------------------------------------------|-----------|
| <b>Summary of Important Costs for 2026 .....</b>                      | <b>3</b>  |
| <b>SECTION 1 Changes to Benefits &amp; Costs for Next Year.....</b>   | <b>4</b>  |
| Section 1.1 Changes to the Monthly Plan Premium .....                 | 4         |
| Section 1.2 Changes to Your Maximum Out-of-Pocket Amount.....         | 4         |
| Section 1.3 Changes to the Provider Network .....                     | 5         |
| Section 1.4 Changes to the Pharmacy Network.....                      | 5         |
| Section 1.5 Changes to Benefits & Costs for Medical Services .....    | 6         |
| Section 1.6 Changes to Part D Drug Coverage.....                      | 9         |
| Section 1.7 Changes to Prescription Drug Benefits & Costs.....        | 10        |
| <b>SECTION 2 How to Change Plans.....</b>                             | <b>12</b> |
| Section 2.1 Deadlines for Changing Plans.....                         | 12        |
| Section 2.2 Are there other times of the year to make a change? ..... | 12        |
| <b>SECTION 3 Get Help Paying for Prescription Drugs.....</b>          | <b>13</b> |
| <b>SECTION 4 Questions?.....</b>                                      | <b>14</b> |
| Get Help from Elevate Medicare Choice (HMO D-SNP) .....               | 14        |
| Get Free Counseling about Medicare .....                              | 15        |
| Get Help from Medicare .....                                          | 15        |
| Get Help from Medicaid .....                                          | 15        |

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## Summary of Important Costs for 2026

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† Your provider must obtain prior authorization from our plan.

|                                                                                                                                                                                                                                                                                                                                      | 2025<br>(this year)                                                                                                                                       | 2026<br>(next year)                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Monthly plan premium*</b><br>* Your premium can be higher than this amount. Go to Section 1.1 for details.                                                                                                                                                                                                                        | \$0                                                                                                                                                       | \$0                                                                                                                                                       |
| <b>Maximum out-of-pocket amount</b><br>This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services.<br>(Go to Section 1.2 for details.)                                                                                                                                                                  | \$9,250<br><br>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. | \$9,250<br><br>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. |
| <b>Primary care office visits</b>                                                                                                                                                                                                                                                                                                    | \$0 copay per visit                                                                                                                                       | \$0 copay per visit                                                                                                                                       |
| <b>Specialist office visits</b>                                                                                                                                                                                                                                                                                                      | \$0 copay per visit                                                                                                                                       | \$0 copay per visit                                                                                                                                       |
| <b>Inpatient hospital stays</b><br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. | \$0 copay                                                                                                                                                 | \$0 copay                                                                                                                                                 |
| <b>Part D drug coverage deductible</b><br>(Go to Section 1.7 for details.)                                                                                                                                                                                                                                                           | \$0                                                                                                                                                       | \$0                                                                                                                                                       |



|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 2025<br>(this year) | 2026<br>(next year)                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Maximum out-of-pocket amount</b><br><br>Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.<br><br>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.<br><br>Your costs for covered medical services (such as copayments) <b>count</b> toward your maximum out-of-pocket amount. Your costs for prescription drugs <b>don't count</b> toward your maximum out-of-pocket amount. | \$9,250             | <b>Once you've paid \$9,250 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services for the rest of the calendar year.</b> |

### Section 1.3 Changes to the Provider Network

There are no changes to our network of providers for next year.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) for help. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.2 of your *Evidence of Coverage*.

### Section 1.4 Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are no changes to our network of pharmacies for next year.

We can make changes to the pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) for help.

## Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare and Medicaid benefits and costs.

† Your provider must obtain prior authorization from our plan.

|                                                         | 2025<br>(this year)                                                                                             | 2026<br>(next year)                                                                                    |
|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <b>Ambulance Services †</b>                             | No prior authorization required for non-emergency Medicare air ambulance services.                              | Prior authorization is required for non-emergency Medicare air ambulance services.                     |
| <b>Blood Pressure Monitor</b>                           | One blood pressure monitor is covered for eligible members under Supplemental Benefits for the Chronically Ill. | One blood pressure monitor is <u>not</u> covered.                                                      |
| <b>Chronic pain management and treatment services</b>   | Medicare-covered chronic pain management and treatment services benefit is <u>not</u> covered.                  | Medicare-covered chronic pain management and treatment services benefit is covered.                    |
| <b>Colorectal Cancer Screening (Barium Enemas)</b>      | \$0 copay for each Medicare-covered barium enema.                                                               | Medicare-covered barium enema benefit is <u>not</u> covered.                                           |
| <b>Dental Benefits (Extra Benefits offered by DHMP)</b> | You pay \$0 up to the \$5,000 annual maximum benefit for preventive, comprehensive, and major dental services.  | You pay \$0 up to the \$2,000 annual maximum benefit for preventive and comprehensive dental services. |
| <b>Fitness Membership</b>                               | Fitness membership is covered.                                                                                  | Fitness membership is <u>not</u> covered.                                                              |

|                                                                                  | 2025<br>(this year)                                                                                                                                                                                                      | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>FlexCard:<br/>Over-the-Counter (OTC)<br/>and Healthy Food*<br/>Allowances</b> | <p>You will receive up to:</p> <ul style="list-style-type: none"> <li>• \$260 per quarter for OTC items</li> <li>• \$310 per quarter for Healthy Food items through Value Based Insurance Design (VBID) model</li> </ul> | <p>You will receive up to:</p> <ul style="list-style-type: none"> <li>• \$35 per quarter for OTC items</li> <li>• \$75 per month for Healthy Food* items</li> </ul> <p>*This benefit is for those who qualify under Special Supplemental Benefits for the Chronically Ill (SSBCI). See eligibility details at the end of this table.</p> |
| <b>Nutritional / Dietary Benefit</b>                                             | Nutritional/dietary benefit is covered.                                                                                                                                                                                  | Nutritional/dietary benefit is <u>not</u> covered                                                                                                                                                                                                                                                                                        |
| <b>Pre-exposure prophylaxis (PrEP) for HIV prevention</b>                        | Medicare-covered pre-exposure prophylaxis (PrEP) for HIV prevention benefit is <u>not</u> covered.                                                                                                                       | \$0 copay                                                                                                                                                                                                                                                                                                                                |
| <b>Screening for Hepatitis C Virus infection</b>                                 | Medicare-covered screening for Hepatitis C Virus infection benefit is <u>not</u> covered.                                                                                                                                | \$0 copay                                                                                                                                                                                                                                                                                                                                |
| <b>Skilled Nursing Facility (SNF) Care†</b>                                      | No prior authorization required for Medicare-covered SNF stays.                                                                                                                                                          | Prior authorization is required for Medicare-covered SNF stays.                                                                                                                                                                                                                                                                          |

|                                                           | 2025<br>(this year)                                                                                                                                 | 2026<br>(next year)                                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Smartphone with Unlimited Data Plan*</b>               | Smartphone benefit is <u>not</u> covered.                                                                                                           | <p>Smartphone with unlimited data plan* is covered through Thrive Mobile.</p> <p>Eligible members are covered for a no-cost smartphone and no monthly bill (unlimited text, talk, and data).</p> <p>*This benefit is for those who qualify under Special Supplemental Benefits for the Chronically Ill (SSBCI). See eligibility details at the end of this table.</p> |
| <b>Transportation Services</b>                            | \$0 copay for unlimited round-trip non-emergency medical transportation to plan approved health-related locations.                                  | \$0 copay for 24 one-way trips for non-emergency medical transportation to plan approved health-related locations.                                                                                                                                                                                                                                                    |
| <b>Value-Based Insurance Design (VBID) Model Benefits</b> | <p>Transportation is covered under Value-Based Insurance Design (VBID)</p> <p>Healthy Food is covered under Value-Based Insurance Design (VBID)</p> | <p>Transportation is covered. See “Transportation Services.”</p> <p>Healthy Food* is covered. See “FlexCard.”</p>                                                                                                                                                                                                                                                     |
| <b>Vision Care</b>                                        | Up to \$245 for prescription contact lenses and/or eyeglasses (lenses and frames) every year.                                                       | Up to \$300 for prescription contact lenses and/or eyeglasses (lenses and frames) every year.                                                                                                                                                                                                                                                                         |

\*This benefit is part of a special supplemental program for the chronically ill. Not all members qualify. Other eligibility and coverage criteria apply. Eligible conditions include chronic alcohol use disorder and other substance use disorders (SUDs), autoimmune disorders, cancer, cardiovascular disorders, chronic heart failure, dementia, diabetes mellitus, overweight/obesity/metabolic syndrome, chronic gastrointestinal disease, chronic kidney disease (CKD), severe hematologic disorders, HIV/AIDS, chronic lung disorders, chronic and disabling mental health conditions, neurologic disorders, stroke, post-organ transplantation, immunodeficiency and immunosuppressive disorders, conditions associated with cognitive impairment, conditions with functional challenges, chronic conditions that impair vision/hearing (deafness)/taste/touch/smell, and conditions that require continued therapy services in order for individuals to maintain or retain functioning.

## Section 1.6 Changes to Part D 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, we might make other changes that are allowed by Medicare rules that will affect you during the calendar year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you're taking, we'll send you a notice about the change.

If you're affected by a change in drug coverage at the beginning of the year or during the year, review Chapter 9 of your *Evidence of Coverage* and talk to your prescriber to find out your options, such as asking for a temporary supply, applying for an exception, and/or working to find a new drug. Call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) for more information.

## Section 1.7 Changes to Prescription Drug Benefits & Costs

### Do you get Extra Help to pay for your drug coverage costs?

If you're in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D drugs does not apply to you.** We have included a separate material, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*, which tells about your drug costs. If you get Extra Help and didn't get this material with this packet, call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) and ask for the *LIS Rider*.

### Drug Payment Stages

There are 3 **drug payment stages**: the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program no longer exist in the Part D benefit.

- **Stage 1: Yearly Deductible**

We have no deductible, so this payment stage doesn't apply to you.

- **Stage 2: Initial Coverage**

In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date Out-of-Pocket costs reach \$2,100.

- **Stage 3: Catastrophic Coverage**

This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program don't count toward out-of-pocket costs.

### Drug Costs in Stage 1: Yearly Deductible

The table shows your cost per prescription during this stage.

|                          | 2025<br>(this year)                                                     | 2026<br>(next year)                                                     |
|--------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <b>Yearly Deductible</b> | Because we have no deductible, this payment stage doesn't apply to you. | Because we have no deductible, this payment stage doesn't apply to you. |

### Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month (30-day) supply filled at a network pharmacy with standard cost sharing.

Most adult Part D vaccines are covered at no cost to you. For more information about the costs of vaccines, or information about the costs for a long-term supply or for mail-order prescriptions, go to Chapter 6 of your Evidence of Coverage.

Once you've paid \$2,100 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

|  | 2025<br>(this year) | 2026<br>(next year)                                                                                                                                                                                       |
|--|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | \$0 copay           | Generic Drugs (including brand drugs treated as generic), either:<br>\$0 copay; or<br>\$1.60 copay; or<br>\$5.10 copay;<br><br>For all other drugs:<br>\$0 copay; or<br>\$4.90 copay; or<br>\$12.65 copay |

### Changes to your VBID Part D Benefit

\$0 Part D cost-sharing through VBID is ending effective January 1, 2026.

### Changes to the Catastrophic Coverage Stage

**If you reach the Catastrophic Coverage Stage, you pay nothing for your covered Part D drugs.**

For specific information about your costs in the Catastrophic Coverage Stage, go to Chapter 6, Section 6, in your *Evidence of Coverage*.

## SECTION 2 How to Change Plans

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

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan**, enroll in the new plan. You'll be automatically disenrolled from Elevate Medicare Choice (HMO D-SNP).
- **To change to Original Medicare with Medicare drug coverage**, enroll in the new Medicare drug plan. You'll be automatically disenrolled from Elevate Medicare Choice (HMO D-SNP).
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (go to Section 3).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit [www.Medicare.gov](http://www.Medicare.gov), check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 4), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, Elevate Medicare Advantage offers other Medicare health plans and Medicare drug plans. These other plans can differ in coverage, monthly plan premiums, and cost-sharing amounts.

### Section 2.1 Deadlines for Changing Plans

People with Medicare can make changes to their coverage from **October 15 – December 7** each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

### Section 2.2 Are there other times of the year to make a change?

In certain situations, people may have other chances to change their coverage during the year. Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

Because you have Health First Colorado – Colorado's Medicaid Program, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

If you recently moved into or currently live in 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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

### **SECTION 3      Get Help Paying for Prescription Drugs**

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You may qualify for help paying for prescription drugs. Different kinds of help are available:

- **Extra Help from Medicare.** People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday – Friday for a representative. Automated messages are available 24 hours a day. TTY users can call, 1-800-325-0778.
  - Your State Medicaid office.

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. Medicare Part D drugs that are also covered by ADAP qualify for prescription cost-sharing help through the Colorado AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call Colorado AIDS Drug Assistance Program at 303-692-2716 (TTY 711). Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in the Medicare Prescription Payment Plan, regardless of income level. To learn more about this payment option, call us at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

## SECTION 4      Questions?

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### Get Help from Elevate Medicare Choice (HMO D-SNP)

- **Call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111. (TTY users call 711.)**

We're available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

- **Read your 2026 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the *2026 Evidence of Coverage* for Elevate Medicare Choice (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of Coverage* on our website at [DenverHealthMedicalPlan.org](http://DenverHealthMedicalPlan.org) or call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111 (TTY users call 711) to ask us to mail you a copy.

- Visit [DenverHealthMedicalPlan.org](https://denverhealthmedicalplan.org)

Our website has the most up-to-date information about our provider network (*Provider Directory/Pharmacy Directory*) and our *List of Covered Drugs* (formulary/Drug List).

## Get Free Counseling about Medicare

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.

Call Colorado State Health Insurance Assistance Program to get free personalized health insurance counseling. They can help you understand your Medicare and Medicaid plan choices and answer questions about switching plans. Call Colorado State Health Insurance Assistance Program at 1-888-696-7213. Learn more about Colorado State Health Insurance Assistance Program by visiting (<https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare>).

## Get Help 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 can call 1-877-486-2048.

- Chat live with [www.Medicare.gov](https://www.Medicare.gov)

You can chat live at [www.Medicare.gov/talk-to-someone](https://www.Medicare.gov/talk-to-someone).

- Write to Medicare

You can write to Medicare at PO Box 1270, Lawrence, KS 66044.

- Visit [www.Medicare.gov](https://www.Medicare.gov)

The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.

- Read *Medicare & You 2026*

The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at [www.Medicare.gov](https://www.Medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

## Get Help from Medicaid

Call Health First Colorado – Colorado’s Medicaid Program at 1-800-221-3943 (TTY users call 711) for help with Medicaid enrollment or benefit questions.

## 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 Sprachassistentendienste 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.

#### :Arabicالعربية:

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