

**ELEVATE
MEDICARE ADVANTAGE**

Denver Health Medical Plan Inc.™

Elevate Medicare Select (HMO) offered by Elevate Medicare Advantage (Elevate Medicare Advantage)

Annual Notice of Changes for 2025

You are currently enrolled as a member of Elevate Medicare Select (HMO). 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](https://denverhealthmedicalplan.org). You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 coverage restrictions and cost sharing.
 - Think about how much you will spend on premiums, deductibles, and cost sharing.
 - Check the changes in the 2025 “Drug List” to make sure the drugs you currently take are still covered.
 - Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.
- ☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.
- ☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for “Extra Help” from Medicare.

☐ 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 the www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.
- ☐ 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, 2024, you will stay in Elevate Medicare Select (HMO).
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025**. This will end your enrollment with Elevate Medicare Select (HMO).
- If you recently moved into or currently live in 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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

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 information is also available in 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 Select (HMO)

- Elevate Medicare Advantage is a Medicare-approved HMO plan. Enrollment in Elevate Medicare Advantage depends on contract renewal.
- When this document says "we," "us," or "our," it means Elevate Medicare Advantage (Elevate Medicare Advantage). When it says "plan" or "our plan," it means Elevate Medicare Select (HMO).

Annual Notice of Changes for 2025

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for Elevate Medicare Select (HMO) in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
† Your provider must obtain prior authorization from our plan.		
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	\$0	\$0
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.)	\$4,900	\$6,750
Doctor office visits	Primary care visits: \$0 copay per visit Specialist visits: \$15 copay per visit, \$35 copay for minor procedure in a specialist's office	Primary care visits: \$0 copay per visit Specialist visits: \$15 copay per visit, \$35 copay for minor procedure in a specialist's office

Cost	2024 (this year)	2025 (next year)
Inpatient hospital stays†	<p>Plan covers 90 days per benefit period.</p> <ul style="list-style-type: none"> • Days 1–5: \$250 per day for each benefit period • Days 6–90: \$0 per day for each benefit period • Days 91–150: \$800 per day for each “lifetime reserve day” (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs 	<p>Plan covers 90 days per benefit period.</p> <ul style="list-style-type: none"> • Days 1–5: \$350 per day for each benefit period • Days 6–90: \$0 per day for each benefit period • Days 91–150: \$816 per day for each “lifetime reserve day” (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs
Part D prescription drug coverage (See Section 1.5 for details.)	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1 (Preferred Generic): \$0 at a network pharmacy • Drug Tier 2 (Generic): \$9 at a network pharmacy • Drug Tier 3 (Preferred Brand): \$47 at a network pharmacy • Drug Tier 4 (Non-Preferred Brand): \$95 at a network pharmacy • Drug Tier 5 (Specialty Tier): 33% of the total cost at a network pharmacy • Drug Tier 6 (Select Care Drugs): \$0 at a network pharmacy 	<p>Deductible: \$0</p> <p>Copayment/Coinsurance during the Initial Coverage Stage:</p> <ul style="list-style-type: none"> • Drug Tier 1 (Preferred Generic): \$0 at a preferred network pharmacy or \$15 at a network pharmacy • Drug Tier 2 (Generic): \$9 at a preferred network pharmacy or \$20 at a network pharmacy • Drug Tier 3 (Preferred Brand): \$45 at a preferred network pharmacy or \$47 at a network pharmacy • Drug Tier 4 (Non-Preferred Brand): \$95 at a preferred network pharmacy or \$100 at a network pharmacy

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (continued) (See Section 1.5 for details.)	<ul style="list-style-type: none">• Drug Tier 5 (Specialty Tier): 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a network pharmacy• Drug Tier 6 (Select Care Drugs): \$0 at a preferred network pharmacy or \$0 at a network pharmacy <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.	<ul style="list-style-type: none">• Drug Tier 5 (Specialty Tier): 33% of the total cost at a preferred network pharmacy or 33% of the total cost at a network pharmacy• Drug Tier 6 (Select Care Drugs): \$0 at a preferred network pharmacy or \$0 at a network pharmacy <p>Catastrophic Coverage:</p> <ul style="list-style-type: none">• During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	\$0	\$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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	2024 (this year)	2025 (next year)
Maximum out-of-pocket amount 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.	\$4,900	\$6,750 Once you have paid \$6,750 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

Amounts you pay for your prescription drugs may 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. Our network includes pharmacies with

preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other network pharmacies for some drugs.

Updated directories are located on our website at [DenverHealthMedicalPlan.org](https://denverhealthmedicalplan.org). 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 no changes to our network of providers for next year.

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

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are 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

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

Cost	2024 (this year)	2025 (next year)
† Your provider must obtain prior authorization from our plan.		
Ambulance Services	Prior authorization is required for non-emergency Medicare air ambulance services.	No prior authorization required for non-emergency Medicare air ambulance services.
Cardiac Rehabilitation Services	Referral is required for Medicare-covered cardiac rehabilitation services. Referral is required for Medicare-covered intensive cardiac rehabilitation services.	No referral required for Medicare-covered cardiac rehabilitation services. No referral required for Medicare-covered intensive cardiac rehabilitation services.

Cost	2024 (this year)	2025 (next year)
FlexCard: <i>Over-the-Counter (OTC) and Healthy Food Allowance</i>	<p>You will receive up to \$600 a year:</p> <ul style="list-style-type: none"> • \$75 per quarter for OTC items • \$75 per quarter for Healthy Food <p>The healthy food allowance is a special benefit for the chronically ill and not all members qualify.</p>	<p>You will receive up to \$820 a year:</p> <ul style="list-style-type: none"> • \$130 per quarter for OTC items • \$75 per quarter for Healthy Food <p>The healthy food allowance is a special benefit for the chronically ill and not all members qualify. Other eligibility and coverage criteria apply. Eligible conditions include: Chronic alcohol and other drug dependence, Autoimmune disorders, Cancer, Chronic heart failure, Dementia, Diabetes, End-stage liver disease, End-stage renal disease (ESRD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke.</p>
Home Health Agency Care†	Referral is required for Medicare-covered home health agency services.	No referral required for Medicare-covered home health agency services.

Cost	2024 (this year)	2025 (next year)
Inpatient Hospital Care†	<p>For Medicare-covered inpatient hospital stays, you pay:</p> <ul style="list-style-type: none"> • Days 1–5: \$250 per day for each benefit period • Days 6–90: \$0 per day for each benefit period. • Days 91–150: \$800 per day for each “lifetime reserve day” (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs 	<p>For Medicare-covered inpatient hospital stays, you pay:</p> <ul style="list-style-type: none"> • Days 1–5: \$350 per day for each benefit period • Days 6–90: \$0 per day for each benefit period. • Days 91–150: \$816 per day for each “lifetime reserve day” (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs
Inpatient Services in a Psychiatric Hospital	<p>For Medicare-covered inpatient mental health stays, you pay:</p> <ul style="list-style-type: none"> • Days 1-5: \$250 copay per day for each benefit period. • Days 6-90: \$0 copay per day for each benefit period. • Days 91–150: \$800 per day for each “lifetime reserve day” (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs <p>Prior authorization is required for Medicare-covered inpatient mental health stays.</p>	<p>For Medicare-covered inpatient mental health stays, you pay:</p> <ul style="list-style-type: none"> • Days 1-5: \$350 copay per day for each benefit period. • Days 6-90: \$0 copay day for each benefit period. • Days 91–150: \$816 per day for each “lifetime reserve day” (up to 60 days over your lifetime) • Beyond lifetime reserve days: All costs <p>No prior authorization required for Medicare-covered inpatient mental health stays.</p>

Cost	2024 (this year)	2025 (next year)
Kidney Disease Services	Referral is required for kidney dialysis services. Referral is required for kidney disease education services.	No referral required for kidney dialysis services. No referral required for kidney disease education services.
Opioid Treatment Program Services	Referral is required for opioid treatment program services.	No referral required for opioid treatment program services.
Outpatient Blood Services	Referral is required for outpatient blood services.	No referral required for outpatient blood services.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	Referral is required for outpatient diagnostic procedures and tests. Referral is required for outpatient lab services.	No referral required for outpatient diagnostic procedures or tests. No referral required for outpatient lab services.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies (Continued)	Referral is required for outpatient diagnostic radiology services. Referral is required for outpatient therapeutic radiology services. Referral is required for outpatient X-ray services. Referral is required for outpatient diagnostic procedures and tests.	No referral required for outpatient diagnostic radiology services. No referral required for outpatient therapeutic radiology services. No referral required for outpatient X-ray services. No referral required for outpatient diagnostic procedures or tests.
Outpatient Hospital Observation	Referral is required for outpatient hospital observation services.	No referral required for outpatient hospital observation services.

Cost	2024 (this year)	2025 (next year)
Outpatient Mental Health Care	<p>Referral is required for Medicare-covered individual therapy sessions with a mental health care professional (non-psychiatrist).</p> <p>Referral is required for Medicare-covered group therapy sessions with a mental health care professional (non-psychiatrist).</p> <p>Referral is required for Medicare-covered individual therapy visits with a psychiatrist.</p> <p>Referral is required for Medicare-covered group therapy visits with a psychiatrist.</p>	<p>No referral required for Medicare-covered individual therapy sessions with a mental health care professional (non-psychiatrist).</p> <p>No referral required for Medicare-covered group therapy sessions with a mental health care professional (non-psychiatrist).</p> <p>No referral required for Medicare-covered individual therapy visits with a psychiatrist.</p> <p>No referral required for Medicare-covered group therapy visits with a psychiatrist.</p>
Outpatient Rehabilitation Services†	<p>Referral is required for Medicare-covered occupational therapy services.</p> <p>Referral is required for physical and speech therapy services.</p>	<p>No referral required for Medicare-covered occupational therapy services.</p> <p>No referral required for physical or speech therapy services.</p>
Outpatient Substance Use Disorder Services	<p>Referral is required for Medicare-covered individual sessions for outpatient substance abuse.</p> <p>Referral is required for Medicare-covered group sessions for outpatient substance abuse.</p>	<p>No referral required for Medicare-covered individual sessions for outpatient substance abuse.</p> <p>No referral required for Medicare-covered group sessions for outpatient substance abuse.</p>

Cost	2024 (this year)	2025 (next year)
Outpatient Surgery	Referral is required for outpatient hospital services. Referral is required for services at an ambulatory surgical center.	No referral required for outpatient hospital services. No referral required for services at an ambulatory surgical center.
Partial Hospitalization and Intensive Outpatient Services	Prior authorization is required for Medicare-covered partial hospitalization services.	No prior authorization required for Medicare-covered partial hospitalization services.
Physician/Practitioner Services, Including Doctor's Office Visits	Referral is required for Medicare-covered physician specialist services. Referral is required for services provided by other health care professionals.	No referral required for Medicare-covered physician specialist services. No referral required for services provided by other health care professionals.
Pulmonary Rehabilitation Services	Referral is required for Medicare-covered pulmonary rehabilitation services.	No referral required for Medicare-covered pulmonary rehabilitation services.
Vision Care	Up to \$380 for prescription contact lenses and/or eyeglasses (lenses and frames) every year.	Up to \$220 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, we might make other changes that are allowed by Medicare rules that will affect you during the plan 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 are taking, we will send you a notice about the change.

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.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking an original biological product that is being replaced by a biosimilar, you may not get notice of the change 30 days before we make it or get a month's supply of your original biological product at a network pharmacy. If you are taking the original biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of drug types, please see Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: <https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients>. You may also contact Health Plan Services or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs* (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30th, please call Health Plan Services and ask for the LIS Rider.

Beginning in 2025, there are three **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 will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the 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 do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
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.	Your cost for a one-month supply is: Tier 1 (Preferred Generic): <i>Standard cost sharing:</i> You pay \$0 per prescription. Tier 2 (Generic): <i>Standard cost sharing:</i> You pay \$9 per prescription.	Your cost for a one-month supply is: Tier 1 (Preferred Generic): <i>Standard cost sharing:</i> You pay \$15 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription. Tier 2 (Generic): <i>Standard cost sharing:</i> You pay \$20 per prescription. <i>Preferred cost sharing:</i> You pay \$9 per prescription.

Stage	2024 (this year)	2025 (next year)
<p>We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.</p> <p>Most adult Part D vaccines are covered at no cost to you.</p>	<p>Tier 3 (Preferred Brand): <i>Standard cost sharing:</i> You pay \$47 per prescription.</p>	<p>Tier 3 (Preferred Brand): <i>Standard cost sharing:</i> You pay \$47 per prescription. <i>Preferred cost sharing:</i> You pay \$45 per prescription.</p>
	<p>Tier 4 (Non-Preferred Brand): <i>Standard cost sharing:</i> You pay \$95 per prescription.</p>	<p>Tier 4 (Non-Preferred Brand): <i>Standard cost sharing:</i> You pay \$100 per prescription. <i>Preferred cost sharing:</i> You pay \$95 per prescription.</p>
	<p>Tier 5 (Specialty Tier): <i>Standard cost sharing:</i> You pay 33% of the total cost per prescription.</p>	<p>Tier 5 (Specialty Tier): <i>Standard cost sharing:</i> You pay 33% of the total cost per prescription. <i>Preferred cost sharing:</i> You pay 33% of the total cost per prescription.</p>
	<p>Tier 6 (Select Care Drugs): <i>Standard cost sharing:</i> You pay \$0 per prescription.</p>	<p>Tier 6 (Select Care Drugs): <i>Standard cost sharing:</i> You pay \$0 per prescription. <i>Preferred cost sharing:</i> You pay \$0 per prescription.</p>
	<p>Once your total drug costs have reached \$5,030, you will move to the next stage (the Coverage Gap Stage).</p>	<p>Once you have paid \$2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Coverage Stage).</p>

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

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, look at Chapter 6, Section 6 in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Medicare Prescription Payment Plan	Not applicable	<p>The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).</p> <ul style="list-style-type: none">To learn more about this payment option, please contact us at 303-602-2111 or toll-free 1-877-956-2111 (TTY users should call 711) or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Elevate Medicare Select (HMO)

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 Select (HMO).

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 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. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

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 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Elevate Medicare Advantage offers other Medicare health plans and Medicare prescription drug 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 Select (HMO).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Elevate Medicare Select (HMO).
- 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.

SECTION 4 Deadline for 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, 2025.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2025, 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, 2025.

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 (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. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer 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.

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 (<https://doi.colorado.gov>).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“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 prescription drug premiums, yearly

deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
 - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
 - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your State, individuals 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 prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Colorado Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Colorado Drug Assistance Program at 303-692-2716. 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 new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **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 this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 303-602-2111 or toll-free 1-877-956-2111 (TTY only, call 711.) or visit [Medicare.gov](https://www.Medicare.gov).

SECTION 7 Questions?

Section 7.1 – Getting Help from Elevate Medicare Select (HMO)

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 2025 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 2025. For details, look in the *2025 Evidence of Coverage* for Elevate Medicare Select (HMO). 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](https://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](https://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 7.2 – 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 2025

Read the *Medicare & You 2025* 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.

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 1-877-956-2111 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)