ELEVATE MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.

2025 Summary Of Benefits

Elevate Medicare Select (HMO)

H5608 002

January 1, 2025 December 31, 2025

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)

8a.m. – 8p.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.

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
† 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.	$6,750
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.	• $350 copay per day for each benefit period for days 1-5 • $0 copay per day for each benefit period for days 6-90 • $816 copay per day for days 91-150 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 copay for diagnostic colonoscopy/endoscopy. $275 copay for other Medicare-covered outpatient surgery services provided at outpatient hospital facilities. $205 copay for other Medicare-covered non-surgical services.
Ambulatory Surgical Center	$0 copay for diagnostic colonoscopy/endoscopy. $200 copay for other Medicare-covered outpatient surgery services provided at ambulatory surgical centers.

Benefits and Premiums	You Pay
† Your provider must obtain prior authorization from our plan.	
Doctor Office Visits	Primary Care Visit: $0 copay Specialist Visit: $15 copay for each Medicare-covered physician specialist office visit. $35 copay for each Medicare-covered procedure in a physician specialist's office.
Preventive Care	$0 copay
Emergency Care We cover emergency care anywhere in the United States. ER cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.	$110 copay
Urgently Needed Services We cover urgently needed care anywhere in the United States. Urgently needed care services cost sharing is waived if you are admitted to the hospital within 3 days for the same condition.	$40 copay
Diagnostic Services, Lab and Imaging • Medicare-covered diagnostic tests and procedures • X-rays • Medicare-covered labs	<u>Diagnostic Radiology</u> $35 copay for Medicare-covered diagnostic radiology services performed in an office setting. $160 copay for Medicare-covered diagnostic radiology services performed in an outpatient facility. <u>Therapeutic Radiology</u> $35 copay for Medicare-covered therapeutic radiology services performed in an office setting. $60 copay for Medicare-covered therapeutic radiology services performed in an outpatient facility. $0 copay for Medicare-covered lab services. $35 copay for Medicare-covered X-rays.
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 copay for one routine hearing exam every 3 years. Covered up to $1,500 maximum plan coverage amount every 3 years (for both ears combined) for prescription hearing aids.

Benefits and Premiums	You Pay
† Your provider must obtain prior authorization from our plan.	
Dental Services (Medicare-Covered) Medicare covers some dental services that are closely related to other covered medical services.	$15 copay 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 of 4 per calendar year) • Fluoride treatment (1 treatment per year) • Fillings (up to 2 services per calendar year) • See your EOC for additional dental covered services.	$0 copay for covered services 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 copay for one routine eye exam every year. Up to $220 for prescription contact lenses and/or eyeglasses (lenses and frames) every year.
Inpatient Services in a Psychiatric Hospital Our plan covers up to 90 days for each benefit period and up to 190 days over your lifetime for inpatient mental health care in a psychiatric hospital.	• $350 copay per day for each benefit period for days 1-5 • $0 copay per day for each benefit period for days 6-90 • $816 copay per day for days 91-150 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 copay
Skilled Nursing Facility (SNF) Our plan covers up to 100 days per benefit period. A new benefit period begins after 60 days with no readmission for the same condition.	• $0 copay per day for days 1-20 • $188 copay per day for days 21-44 • $0 copay per day for days 45-100 • Beyond 100 days: all costs
Outpatient Rehabilitation† • Cardiac (Heart) • Pulmonary (Lung) • Occupational Therapy† • Physical Therapy† • Speech Therapy†	$20 copay for each cardiac visit $15 copay for each pulmonary visit $35 copay for each occupational therapy visit $25 copay for each physical and speech therapy visit †Prior authorization required after first 30 visits.

Benefits and Premiums	You Pay
† Your provider must obtain prior authorization from our plan.	
Ambulance	$250 copay If you are admitted to the hospital, you do not have to pay your share of the cost for the ambulance services.
Transportation Unlimited round-trip non-emergent medical transportation to plan approved health-related locations.	$0 copay
Medicare Part B Drugs†	0% to 20% of the total cost for Medicare Part B chemotherapy drugs and other Part B drugs. 0% to 20% of the total cost for Medicare Part B insulin drugs. †Authorization may be required for some 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:

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Preferred retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$15 copay	$0 copay	N/A	$15 copay
Cost-Sharing Tier 2 (Generic)	$20 copay	$9 copay	N/A	$20 copay

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Preferred retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)
Cost-Sharing Tier 3 (Preferred Brand)	$47 copay	$45 copay	N/A	$47 copay
Cost-Sharing Tier 4 (Non-Preferred Brand)	$100 copay	$95 copay	N/A	$100 copay
Cost-Sharing Tier 5 (Specialty Tier)	33% of the total cost	33% of the total cost	33% of the total cost	33% of the total cost
Cost-Sharing Tier 6 (Select Care Drugs)	$0 copay	$0 copay	N/A	$0 copay

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

Your share of the cost when you get a *long-term (up to 100-day)* supply of a covered Part D prescription drug:

Tier	**Standard retail cost sharing (in-network)** (100-day supply)	**Preferred retail cost sharing (in-network)** (100-day supply)	**Standard Mail-order cost sharing** (100-day supply)	**Preferred Mail-order cost sharing** (100-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$45 copay	$0 copay	$45 copay	$0 copay
Cost-Sharing Tier 2 (Generic)	$60 copay	$18 copay	$60 copay	$0 copay

Tier	Standard retail cost sharing (in-network) (100-day supply)	Preferred retail cost sharing (in-network) (100-day supply)	Standard Mail-order cost sharing (100-day supply)	Preferred Mail-order cost sharing (100-day supply)
Cost-Sharing Tier 3 (Preferred Brand)	$141 copay	$135 copay	$141 copay	$135 copay
Cost-Sharing Tier 4 (Non-Preferred Brand)	$300 copay	$285 copay	$300 copay	$285 copay
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.	A long-term supply is not available for drugs in Tier 5.
Cost-Sharing Tier 6 (Select Care Drugs)	$0 copay	$0 copay	$0 copay	$0 copay

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 standard or preferred pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

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 $2,000, 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:

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

Costs may differ based on the pharmacy type (preferred or standard) 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**
† 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. Must be provided by the plan.
Chiropractic Care We cover only manual manipulation of the spine to correct subluxation.	$20 copay
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 copay
Diabetes Supplies and Services† • therapeutic shoes and inserts • diabetic monitoring supplies • diabetes self-management training	$0 copay †TrividiaHealth diabetic testing supplies and Dexcom and certain FreeStyle Libre continuous glucose monitoring systems do not require prior authorization. All other vendors require authorization.
FlexCard: 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. Your allowance is available on your FlexCard at the beginning of each quarter of the plan year (January; April; July and October). 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 the Flex Card for the purchase of eligible healthy foods. Over-the-Counter Allowance • You will receive quarterly funds loaded the FlexCard for the purchase of OTC health and wellness products.	You will receive up to $820 a year: • $75 a quarter for Healthy Food items (for eligible members) • $130 a quarter for Over-the-Counter (OTC) items The healthy food allowance is a special benefit for the chronically ill and not all members qualify.

Additional Benefits	
Benefits	**You Pay**
† Your provider must obtain prior authorization from our plan.	
FlexCard: Healthy Food and Over-the-Counter (OTC) Continued 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.	

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.

This document is available for free in Spanish and other formats such as Braille, large print, or audio.

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.

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)