# Denver Health Medicare Select (HMO) *offered by* Denver Health Medical Plan, Inc.

# Annual Notice of Changes for 2020

You are currently enrolled as a member of Denver Health Medicare Select (HMO). Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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

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## 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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.5 and 1.6 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2020 Drug List and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit https://go.medicare.gov/drugprices. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

OMB Approval 0938-1051 (Expires: December 31, 2021)

☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our Provider Directory.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You handbook.
- Look in Section 2.2 to learn more about your choices.

☐ 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 want to **keep** Denver Health Medicare Select (HMO), you don't need to do anything. You will stay in Denver Health Medicare Select (HMO).
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2019**
   - If you don't join another plan by **December 7, 2019**, you will stay in Denver Health Medicare Select (HMO).
   - If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020.**

## Additional Resources

- This document is available for free in Spanish
- Please contact our Health Plan Services number at 303-602-2111 or toll free at 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

- **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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

## About Denver Health Medicare Select (HMO)

- Denver Health Medical Plan, Inc. is a Medicare-approved HMO plan. Enrollment in a Denver Health Medical Plan depends on contract renewal.
- When this booklet says "we," "us," or "our," it means Denver Health Medical Plan, Inc. When it says "plan" or "our plan," it means Denver Health Medicare Select (HMO).

## Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Denver Health Medicare Select (HMO) in several important areas. **Please note this is only a summary of changes**. A copy of the *Evidence of Coverage* is located on our website at www.denverhealthmedicalplan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*.

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Monthly plan premium*** <br>*Your premium may be higher or lower than this amount. See Section 2.1 for details. | $32.00 | $31.30 |
| **Deductible** | $185 | There is no deductible for Denver Health Medicare Select (HMO) Members. |
| **Maximum out-of-pocket amount** <br>This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details). | $5,500 | $5,500 |
| **Doctor office visits** | Primary care visits: $10 per visit. <br><br>Specialist visits: $30 per visit. | Primary care visits: $0 per visit. <br><br>Specialist visits: $35 per visit. |
| **Inpatient hospital stays** <br>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. | Days 1 – 5: $300 per day. <br><br>Days 6 – 90: $0 per day. <br><br>Days 91 – 150: $578 per lifetime reserve day. | Days 1 – 5: $300 per day. <br><br>Days 6 – 90: $0 per day. <br><br>Days 91 – 150: $578 per lifetime reserve day. |

| | | |
|---|---|---|
| **Part D prescription drug coverage**<br>(See Section 1.6 for details). | Deductible: $375 (tiers 2-5).<br><br>Copayment/Coinsurance during the Initial Coverage Stage:<br><br>• Drug Tier 1- Preferred Generic Drugs: $4 copay for a one month supply; OR $8 copay for a three month supply.<br><br>• Drug Tier 2 - Generic Drugs: $10 copay for a one month supply; OR $20 copay for a three month supply.<br><br>• Drug Tier 3 - Preferred Brand: 25% coinsurance for a one month supply; OR 25% coinsurance for a three month supply.<br><br>• Drug Tier 4 - Non-Preferred Brand Drugs: 50% coinsurance for a one month supply; OR 50% coinsurance for a three month supply.<br><br>• Drug Tier 5 - Specialty Drugs: 25% coinsurance for | Deductible: $250 (tiers 2-5).<br><br>Copayment/Coinsurance during the Initial Coverage Stage:<br><br>• Drug Tier 1- Preferred Generic Drugs: $3 copay for a one month supply; $6 copay for a two month supply; $6 copay for a three month supply.<br><br>• Drug Tier 2 - Generic Drugs: $9 copay for a one month supply; $18 copay for a two month supply; $18 copay for a three month supply.<br><br>• Drug Tier 3 - Preferred Brand: 25% coinsurance for a one month supply; 25% coinsurance for a two month supply; 25% coinsurance for a three month supply.<br><br>• Drug Tier 4 - Non-Preferred Brand Drugs: 50% coinsurance for a one month supply; 50% coinsurance for a two month supply; 50% coinsurance for a three month supply.<br><br>• Drug Tier 5 - Specialty Drugs: 28% coinsurance for a one month supply Drug. |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| | a one month supply Drug<br><br>• Tier 6 - Select Care Drugs: $0 copayment for one month supply; $0 copayment for 90 day supply. | • Tier 6 - Select Care Drugs: $0 copayment for one month supply; $0 copayment for two day supply; $0 copayment for three day supply. |

# *Annual Notice of Changes* for 2020
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# SECTION 1 Changes to Benefits and Costs for Next Year

## Section 1.1 – Changes to the Monthly Premium

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Monthly premium**<br>(You must also continue to pay your Medicare Part B premium). | $32 | $31.30 |

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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 | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Maximum out-of-pocket amount**<br>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount. | $5,500 | $5,500.<br><br>Once you have paid $5,500 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 Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at www.denverhealthmedicalplan.org. You may also call Health Plan Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2020 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

## Section 1.4 – Changes to the Pharmacy Network

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.

## Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage.*

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Colorectal cancer screening** | There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.<br><br>**Prior Authorization rules apply for Medicare-covered barium enemas.** | There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. |
| **Doctor office visits** | You pay a $10 copay for Medicare-covered primary care visits.<br><br>You pay a $30 copay for Medicare-covered specialist visits.<br><br>**Prior Authorization rules apply for physician specialist services.**<br><br>**Referral Required for physician specialist services.** | You pay a $0 copay for Medicare-covered primary care visits.<br><br>You pay a $35 copay for each Medicare-covered specialist visit.<br><br>**Prior Authorization rules apply for specialist visits.**<br><br>**Referral Required for specialist visits.** |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Dental Services** | You pay a $0 copay for Medicare-covered dental benefits.<br><br>You pay a $0 copay for preventive dental services<br>• Up to 2 routine oral exams every year;<br>• Up to 2 cleanings every year; and,<br>• Up to 4 dental x-rays every year.<br><br>You pay a $0 copay for comprehensive dental services:<br>• Up to 2 diagnostic visits every year;<br>• Up to 2 restorative visits every year;<br>• Up to 1 periodontics visit every three years; and<br>• Unlimited extractions. | You pay a $0 copay for Medicare-covered dental benefits.<br><br>You pay a $0 copay for preventive dental services<br>• Up to 2 routine oral exams every year;<br>• Up to 2 cleanings every year;<br>• Up to 1 fluoride treatment every year; and,<br>• Up to 1 dental x-rays every year.<br><br>You pay a $0 copay for comprehensive dental services:<br>• Up to 2 diagnostic visits every year;<br>• Up to 2 restorative visits every year;<br>• Up to 1 periodontics visit every two years; and<br>• Unlimited extractions. |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Health and Wellness** | You pay a $0 copay for health and wellness services.<br><br>Members are offered access to nutrition support groups as well as ongoing group classes regarding diet and nutrition. Health coaches are available to all members and provide on-on-one support as well as group sessions. There is no limitation to the number of times a member can talk to a health coach or attend group session.<br><br>All members have access to 24 hour nursing hotline to ask questions or regarding their health and health concerns. | You pay a $0 copay for health and wellness services.<br><br>Members are offered the "Strong Body Strong Mind" health education services, which include web-paces, self-paced wellness education programs.<br><br>Members are offered unlimited access to individual nutritional education.<br><br>Members have access to a nursing hotline 24/7. |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Hearing** | You pay a $30 copay for Medicare-covered diagnostic hearing exams.<br><br>You pay a $30 copay for up to 1 routine hearing exam every three years.<br><br>You pay a $30 copay for up to 1 fitting/evaluation for a hearing aid every three years.<br><br>You pay a $0 copay for up to $1,500 for hearing aids (both ears combined) every three years. | You pay a $35 copay for Medicare-covered diagnostic hearing exams.<br><br>You pay a $35 copay for up to 1 routine hearing exam every three years.<br><br>You pay a $35 copay for up to 1 fitting/evaluation for a hearing aid every three years.<br><br>You are covered up to $1,000 for hearing aids (both ears combined) every three years. |
| **Occupational Therapy** | You pay a $30 copay per Medicare-covered office visit.<br><br>**Prior Authorization rules apply.**<br><br>**Referral required.** | You pay a $35 copay per Medicare-covered occupational therapy visit.<br><br>**Prior Authorization rules apply.**<br><br>**Referral required.** |
| **Opioid Treatment Services** | Opioid Treatment Services not covered. | There is no coinsurance, copayment, or deductible for the Opioid Treatment Program Services benefit.<br><br>**Referral Required.** |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Outpatient Diagnostic Procedures, Tests and Lab Services** | You pay 20% of the total cost for Medicare-covered outpatient diagnostic tests and therapeutic services, supplies and therapeutic radiological service.<br><br>You pay 0% of the total cost for medical covered lab services.<br><br>**Referral Required.** | You pay 20% of the total cost for Medicare-covered outpatient diagnostic tests and therapeutic services, supplies and therapeutic radiological service.<br><br>You pay a $0 copay for Medicare-covered lab services.<br><br>**Prior Authorization rules apply for Medicare-covered diagnostic procedures/tests and outpatient diagnostic and therapeutic radiological services. (Prior Authorization rules do not apply for Medicare-covered lab services). Referral Required.** |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Outpatient Mental Health Care** | You pay a $10 copay for each Medicare-covered individual therapy visit.<br>You pay a $10 copay for each Medicare-covered group therapy visit.<br>You pay a $10 copay for each Medicare-covered individual therapy visit with a psychiatrist.<br>You pay a $10 copay for each Medicare-covered group therapy visit with a psychiatrist.<br>**Referral Required for visits with a non-psychiatrist.** | $0 copay for each Medicare-covered individual or group therapy visit with or without a psychiatrist.<br>**Referral Required.** |
| **Outpatient Substance Abuse Services** | You pay a $10 copay for each Medicare-covered individual substance abuse outpatient treatment visits.<br>You pay a $10 copay for each Medicare-covered group substance abuse outpatient treatment visits.<br>**Prior Authorization rules apply.**<br>**Referral Required.** | You pay $0 copay for each Medicare-covered individual or group substance abuse outpatient treatment visit.<br>**Referral Required.** |

| Cost | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Podiatry Services** | You pay a $30 copay per each Medicare-covered office visit.<br><br>**Prior Authorization rules apply.**<br><br>**Referral Required.** | You pay a $35 copay per each Medicare-covered podiatry visit.<br><br>**Prior Authorization rules apply.**<br><br>**Referral Required.** |
| **Vision Care** | You pay a $30 copay for Medicare-covered diagnosis and treatment for diseases and conditions of the eye.<br><br>You pay a $0 copay for annual glaucoma screening for people at risk.<br><br>You pay a $30 copay for up to one routine eye exam every year.<br><br>You pay a $0 copay for eyewear and coverage up to $250 for up to one pair of eyeglasses (lenses and frames) or unlimited contact lenses every benefit year. | You pay a $35 copay for Medicare-covered diagnosis and treatment for diseases and conditions of the eye.<br><br>You pay $0 copay for annual glaucoma screening for people at risk.<br><br>You pay a $35 copay for up to one supplemental routine eye exam every year.<br><br>You are covered up to $105 for contact lenses and/or 1 pair of eye glasses (lenses and frames) every year. |

## Section 1.6 – 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, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Health Plan Services.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Health Plan Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage).* During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Formulary exceptions that have been granted will be covered until the end date of the authorization. The exception may extend into the next year.

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules.

When we make these changes to the Drug List during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online Drug List as scheduled and provide other required information to reflect drug changes. (To learn more about changes we may make to the Drug List, see Chapter 5, Section 6 of the Evidence of Coverage).

## Changes to Prescription Drug 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 haven't received this insert by September 30, 2019, please call Health Plan Services and ask for the "LIS Rider." Phone numbers for Health Plan Services are in Section 6.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages).

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which is located on our website at www.denverhealthmedicalplan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*).

### Changes to the Deductible Stage

| Stage | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Stage 1: Yearly Deductible Stage**<br>During this stage, **you pay the full cost** of your Tier 2, 3, 4 and 5 drugs until you have reached the yearly deductible. | The deductible is $375 (tiers 2-5).<br><br>During this stage, you pay $4 cost-sharing for drugs on Tier 1 and $0 for drugs on Tier 6 and the full cost of drugs on Tier 2, Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. | The deductible is $250 (tiers 2-5).<br><br>During this stage, you pay $3 cost-sharing for drugs on Tier 1 and $0 for drugs on Tier 6 and the full cost of drugs on Tier 2, Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible. |

### Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

| Stage | 2019 (this year) | 2020 (next year) |
|---|---|---|
| **Stage 2: Initial Coverage Stage**<br>Once you pay the yearly deductible, you move to the 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.**<br><br>The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply; or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. | Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:<br><br>**Drug Tier 1 Preferred Generic Drugs:** Not subject to the deductible. You pay $4 per prescription.<br><br>**Drug Tier 2 Generic Drugs:** You pay $10 per prescription.<br><br>**Drug Tier 3 Preferred Brand:** You pay 25% of the total cost.<br><br>**Drug Tier 4 Non-Preferred Brand Drugs:** You pay 50% of the total cost.<br><br>**Drug Tier 5 Specialty Drugs:** You pay 25% of the total cost.<br><br>**Drug Tier 6 Select Care Drugs:** Not subject to the deductible. You pay $0.00 per prescription.<br><br>Once your total drugs costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage). | Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:<br><br>**Drug Tier 1 Preferred Generic Drugs:** Not subject to the deductible. You pay $3 per prescription.<br><br>**Drug Tier 2 Generic Drugs:** You pay $9 per prescription.<br><br>**Drug Tier 3 Preferred Brand:** You pay 25% of the total cost.<br><br>**Drug Tier 4 Non-Preferred Brand Drugs:** You pay 50% of the total cost.<br><br>**Drug Tier 5 Specialty Drugs:** You pay 28% of the total cost.<br><br>**Drug Tier 6 Select Care Drugs:** Not subject to the deductible. You pay $0.00 per prescription.<br><br>Once your total drugs costs have reached $4,020, you will move to the next stage (the Coverage Gap Stage). |

### Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

# SECTION 2 Deciding Which Plan to Choose

## Section 2.1 – If you want to stay in Denver Health 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 stay enrolled as a member of our plan for 2020.

## Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2020 follow these steps:

### Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- *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 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2020*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to https://www.medicare.gov and click "Find health & drug plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Denver Health Medical Plan, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

### Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Denver Health 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 Denver Health 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 this (phone numbers are in Section 6.1 of this booklet).
    - – *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 3 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, 2020.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage plan for January 1, 2020, 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, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

## SECTION 4 Programs That Offer Free Counseling about Medicare

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

Colorado State Health Insurance Assistance Program (Colorado SHIP) is independent (not connected with any insurance company or health plan). 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 (Colorado SHIP) 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 (Colorado SHIP) at toll free 1-888-696-7213. You can learn more about Colorado State Health Insurance Assistance Program (Colorado SHIP) by visiting their website https://www.colorado.gov/pacific/dora/ship-locations.

## SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"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, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. 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 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **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. 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 AIDS Drug Assistance Program (ADAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 303-692-2700 or 303-692-2716.

## SECTION 6 Questions?

### Section 6.1 – Getting Help from Denver Health Medicare Select (HMO)

Questions? We're here to help. Please call Health Plan Services at 303-602-2111 or 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 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Denver Health 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

www.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 www.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 6.2 – 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

You can visit the Medicare website (https://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to https://www.medicare.gov and click on "Find health & drug plans").

### Read *Medicare & You 2020*

You can read the *Medicare & You 2020* Handbook. Every year in the fall, this booklet 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 booklet, you can get it at the Medicare website (https://www.medicare.gov) 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.