



This information is not a complete description of benefits. Contact the plan for more information. Benefits, premiums, and copayments/coinsurance may change on January 1 of each year. To get a complete list of services we cover, call us and ask for the “Evidence of Coverage.”

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Denver Health Medicare Choice (HMO D-SNP)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Denver Health Medicare Choice (HMO D - SNP)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <https://www.medicare.gov>.
- 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 <https://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.

Sections in this booklet

- Things to Know About **Denver Health Medicare Choice (HMO D-SNP)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This information is available in other formats such as Braille and large print.

If you speak Spanish, language assistance services, free of charge are available to you. Please call Health Plan Services at 1-877-956-2111. TTY should call 711. Our hours of operation are 8:00 a.m. - 8:00 p.m., 7 days a week.

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Para obtener más información llámenos al 1-877-956-2111. TTY 711. Los usuarios de TTY deben llamar al 711. Nuestro horario de atención es de 8 a.m. a 8 p.m. los siete días de la semana.

Things to Know About Denver Health Medicare Choice (HMO D-SNP)

Denver Health Medical Plan, Inc. is a Medicare-approved HMO plan. Enrollment in a Denver Health Medical Plan depends on contract renewal. The plan also has a written agreement with the Colorado Medicaid Program to coordinate your Medicaid benefits.

Denver Health Medicare Choice (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 2020 based on a review of Denver Health Medicare Choice (HMO D-SNP) Model of Care.

Hours of Operation

- From October 1 to March 31 you can call us 7 days a week from 8 a.m. to 8 p.m.
- From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m.

Denver Health Medicare Choice (HMO D-SNP) Phone Numbers and Website

- If you are a current member or not a member we can be reached toll-free at 1-877-956-2111. TTY users should call 711.
- Our website is: www.denverhealthmedicalplan.org.

Who can join?

This plan is available to anyone who has both Medical Assistance from the State and Medicare and resides in our service area.

Our service area includes the following county in Colorado: **Denver**

Which doctors, hospitals, and pharmacies can I use?

Denver Health Medicare Choice (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You must generally use the network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's *Provider and Pharmacy Directories* at our website www.denverhealthmedicalplan.org.

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare.**
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.
- **You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services, including copays and coinsurance. You do not pay anything for the services listed in the Benefits Chart, as long as you remain eligible for both Medicare and Medicaid.**

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

SECTION II - SUMMARY OF BENEFITS

How will I determine my drug costs?

The amount you pay for drugs depends on the drug you are taking and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

How much is the monthly premium?

\$31.30 per month. In addition, you must keep paying your Medicare Part B premium.

If you are eligible for Medicare cost-sharing assistance under Medicaid, your premium will be paid for you by Medicaid. You do not pay anything for the premium.

How much is the deductible?

This plan has deductibles for some hospital and medical services, and Part D prescription drugs.

The Part B deductible for 2020 is \$198, and applies to in-network services.

The Part D deductible for 2020 is \$435, and applies to prescription drugs.

If you are eligible for Medicare cost-sharing assistance under Medicaid, your deductibles will be paid for you by Medicaid. You do not pay anything for the services.

Is there any limit on how much I will pay for my covered services?

Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.

In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid eligibility.

Your yearly limit(s) in this plan:

- \$6,700 for services you receive from in-network providers

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.

Refer to the “**Medicare & You**” handbook for Medicare-covered services. For Medicaid-covered services, refer to the Medicaid Coverage section in this document.

Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

Is there a limit on how much the plan will pay?

Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Covered Medical And Hospital Benefits

Note:

Premium, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

This information is not a complete description of benefits. Contact the plan for more information at 1-877-956-2111. TTY users should call 711. Limitations, copayments, and restrictions may apply. Benefits, premiums, and copayments/coinsurance may change on January 1 of each year.

- Services with a 1 may require prior authorization.
- Services with a 2 may require a referral from your doctor.

SECTION II - SUMMARY OF BENEFITS

Inpatient Hospital Care ^{1,2}

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra days, your inpatient hospital coverage will be limited to 90 days per benefit period.

In 2020, the amounts for each benefit period are:

\$1,408 deductible for each benefit period.

- Days 1 – 60: \$0 copay per day of each benefit period
- Days 61 – 90: \$352 copay per day of each benefit period
- Days 91 – and beyond: \$704 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime).

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

You will not be charged additional cost-sharing for professional services.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

SECTION II - SUMMARY OF BENEFITS

<p>Outpatient Hospital Services 1,2</p>	<p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>20% of the cost for each Medicare-covered outpatient hospital facility visit</p> <ul style="list-style-type: none">• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery• Laboratory and diagnostic tests billed by the hospital (<i>Authorization rules DO NOT apply for Medicare-covered lab services.</i>)• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it• X-rays and other radiology services billed by the hospital• Medical supplies such as splints and casts• Certain drugs and biologicals that you can't give yourself <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p> <p><i>Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."</i></p> <p><i>If you are not sure if you are an outpatient, you should ask the hospital staff.</i></p>
<p>Ambulatory Surgery Center 1,2</p>	<p>20% of the cost for Medicare-covered outpatient surgery services provided at ambulatory surgical centers.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>
<p>Doctor's Office Visits 1,2</p>	<p>Primary Care Visit: 20% of the cost Specialist Visit 1,2: 20% of the cost</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>

SECTION II - SUMMARY OF BENEFITS

Preventive Care	<p>You pay \$0.</p> <p>Our plan covers many preventive services, including</p> <ul style="list-style-type: none">• Abdominal aortic aneurysm screening• Alcohol misuse counseling and screening• Bone mass measurement• Breast cancer screening (mammogram)• Cardiovascular disease (behavioral therapy)• Cardiovascular screenings• Cervical and vaginal cancer screening• Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy)• Depression screening• Diabetes screenings• Diabetes self-management training (<i>Authorization rules apply.</i>)• Health and wellness education programs• HIV screening• Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots• Lung cancer screening (LDCT)• Medical nutrition therapy services• Obesity screening and counseling• Prostate cancer screenings (PSA)• Sexually transmitted infections screening and counseling• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)• “Welcome to Medicare” preventive visit (one-time)• Yearly “Wellness” visit <p>Any additional preventive services approved by Medicare during the contract year will be covered.</p>
Emergency Care	<p>20% of the cost (up to \$90)</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>
Urgently Needed Services	<p>20% of the cost (up to \$65)</p> <p>If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgently needed services. See the “Inpatient Hospital Care” section of this booklet for other costs.</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>

SECTION II - SUMMARY OF BENEFITS

<p>Diagnostic Procedures/Tests/Lab Services; Diagnostic/Therapeutic Radiology Services <i>(Costs for these services may be different if received in an Outpatient Surgery setting)</i>^{1,2}</p>	<p>Diagnostic tests and procedures: 20% of the cost Lab services: 20% of the cost (<i>Authorization rules DO NOT apply for Medicare-covered lab services.</i>) Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost Outpatient x-rays: 20% of the cost Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>
<p>Hearing Services</p>	<p>Exam to diagnose and treat hearing and balance issues: 20% of the cost</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p> <p>Routine hearing exam (for up to 1 every three years): \$0 Hearing aid fitting/evaluation (for up to 1 every three years): \$0 Hearing aids: Our plan pays up to \$1,000 every three years for hearing aids.</p>
<p>Dental Services</p>	<p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover limited dental services, subject to Delta Dental Processing Policies, limitations, and exclusions. All claims are subject to dental consultant review:</p> <p>This information is not a complete description of the benefits. Limitations, copayments, and restrictions may apply.</p> <p>Please see the EOC, Chapter 4, pages 58-60 for complete description of the benefits.</p> <p>The Maximum Plan Benefit Coverage amount will be \$1,500 per year.</p>
<p>Vision Services</p>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 20% of the cost</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p> <p>Supplemental routine eye exam (for up to 1 every year): \$0 Contact lenses and/or Eyeglasses (frames and lenses): Our plan pays up to \$105 every year for contact lenses and/or eyeglasses (frames and lenses).</p>

SECTION II - SUMMARY OF BENEFITS

Mental Health Care ^{1,2}

Inpatient Visits ^{1,2}

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

In 2020 the amounts for each benefit period are:

- \$1,408 deductible for each benefit period
- \$0 coinsurance for days 1-60
- \$352 copay per day for days 61 through 90
- \$704 copay per day for 60 lifetime reserve days

Outpatient Visits ²

Outpatient group therapy visit: 20% of the cost

Outpatient individual therapy visit: 20% of the cost

If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

SECTION II - SUMMARY OF BENEFITS

Skilled Nursing Facility (SNF) ^{1,2}	Our plan covers up to 100 days in a SNF. In 2020, the amounts for each benefit period are \$0 or: <ul style="list-style-type: none">• You pay nothing for days 1 through 20• \$176 copay per day for days 21 through 100 If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Outpatient Rehabilitation ^{1,2}	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 20% of the cost Pulmonary (lung) rehab services: 20% of the cost Occupational therapy visit: 20% of the cost Physical therapy visit: 20% of the cost Speech therapy visit: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Ambulance	20% of the cost If you are admitted to the hospital, you do not have to pay for the ambulance services. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Transportation ¹	\$0. 25 round trips to health-related plan-approved locations each year.
Medicare Part B Drugs ¹	Part B Chemotherapy drugs: 20% of the cost Other Part B drugs: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

SECTION II - SUMMARY OF BENEFITS

Diabetes Supplies and Services ¹	Diabetic therapeutic shoes or inserts: 20% of the cost Diabetic supplies: 20% of the cost <i>Diabetic glucometers and test strips are limited to Trividia Health Product. Glucometers and test strips made by other manufactures require an organization determination.</i> Diabetes self-management training: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Home Health Care ^{1,2}	\$0 Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: <ul style="list-style-type: none">• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)• Physical therapy, occupational therapy, and speech therapy• Medical and social services Medical equipment and supplies
Outpatient Substance Abuse ²	Group therapy visit ² : 20% of the cost Individual therapy visit ² : 20% of the cost
Opioid Treatment Services ²	Group therapy visit: 20% of the cost Individual therapy visit: 20% of the cost Treatment medications: 20% of the cost Toxicology testing: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Outpatient Surgery ^{1,2}	Outpatient hospital: 20% of the cost. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

SECTION II - SUMMARY OF BENEFITS

Prosthetic Devices (<i>braces, artificial limbs, etc.</i>). ¹	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Renal Dialysis ^{1,2}	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details. <i>You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.</i>
Meals ¹	You pay \$0 for up to 20 meals delivered to your home, within a 10-day period, after each inpatient hospital or skilled nursing facility discharge.

Prescription Drug Benefits

Initial Coverage

Depending on your income and institutional status, you pay the following:
For generic drugs (including brand drugs treated as generic), either:

- \$0 copay; or
- \$1.30 copay; or
- \$3.60 copay; or
- 25% coinsurance.

For all other drugs, either:

- \$0 copay; or
- \$3.90 copay; or
- \$8.95 copay; or
- 25% coinsurance.

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

You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

You can get drugs the following way:

Retail Pharmacy

Contact your plan if you have questions about cost-sharing or billing if less than a one-month supply is dispensed.

You can get drugs the following way(s):

One-month (30-day) supply

Two-month (60-day) supply

Three-month (90-day) supply

Long term care pharmacy

Long term care pharmacies must dispense brand name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

Mail Order

Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.denverhealthmedicalplan.org on the web.

Prescription Drug Benefits

Coverage Gap Stage	<p>Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches \$4,020.</p> <p>After you enter the coverage gap, you pay 25% of the plan’s cost for covered brand name drugs and 25% of the plan’s cost for covered generic drugs until your costs total \$6,350, which is the end of the coverage gap. Not everyone will enter the coverage gap. For more information, call us at 303-602-2111 or at 1- 877- 956-2111. 711 for TTY users, or you can access our Evidence of Coverage online.</p>
Catastrophic Coverage	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay the greater of:</p> <ul style="list-style-type: none">• 5% of the cost, or• \$3.60 copay for generic (including brand drugs treated as generic) and a \$8.95 co-payment for all other drugs. <p>For more information, call us at 303-602-2111 or toll free at 1-877-956-2111. 711 for TTY users, or you can access our Evidence of Coverage online at www.denverhealthmedicalplan.org.</p>

Summary of Benefits
 For Contract H5608, Plan 001
 Denver Health Medicare Choice (HMO D-SNP)

Medicare Part A (hospital insurance), Part B (Medical Insurance) and Part D (prescription drug coverage) benefits provide your primary insurance coverage. Your eligibility for Title XIX Medicaid pays all remaining hospital, medical and prescription drug coverage cost-sharing including deductibles and coinsurance.

The services listed below are available only to those SNP members eligible under Medicaid for Medical Services.

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Inpatient Hospital Care (includes substance abuse and rehabilitation)	Benefit Covered at 100% \$0 copay under Medicaid Choice. \$10.00 copay per covered day or 50% of the averaged allowable daily rate whichever is less under Medicaid fee-for-service (FFS).	In 2020, the amounts for each benefit period are \$0 or: <ul style="list-style-type: none"> • \$1,408 deductible • \$0 coinsurance for 1-60 days. • \$352 copay per day for days 61 through 90. • \$704 copay per day for 60 lifetime reserve days.
Inpatient Mental Health Care	Benefit covered at 100%. \$0 copay for Medicaid Choice \$0 copay for Medicaid FFS	In 2020, the amounts for each benefit period are \$0 or: <ul style="list-style-type: none"> • \$1,408 deductible • \$0 coinsurance for 1-60 days. • \$352 copay per day for days 61 through 90 • \$704 copay per day for 60 lifetime reserve days.

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Skilled Nursing Facility	Benefit covered at 100%. \$0 copay for Medicaid Choice \$0 copay for Medicaid FFS	Our plan covers up to 100 days in a SNF. In 2020, the amounts for each benefit period are \$0 or: <ul style="list-style-type: none"> • You pay nothing for days 1 through 20 • \$176 copay per day for days 21 through 100.
Acute Home Health and Long Term with Acute Episode Home Health	Benefit covered at 100%. \$0 copay for Medicaid Choice \$0 copay for Medicaid FFS	Covered, \$0 copay
Home Health Services provided specifically as benefits through the Home and Community Based Services Program	Benefit covered at 100%. \$0 copay for Medicaid Choice \$0 copay for Medicaid FFS	Covered, \$0 Copay
Long Term Home Health	Benefit covered at 100%. \$0 copay for Medicaid Choice \$0 copay for Medicaid FFS	Covered, \$0 Copay
Hospice	Benefit covered at 100%. \$0 copay for Medicaid Choice \$0 copay for Medicaid FFS	Covered, Original Medicare

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Primary Care	Benefit covered at 100%. \$0 copay under Medicaid Choice. \$2.00 copay per visit under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Specialty Care	Benefit covered at 100%. \$0 copay under Medicaid Choice. \$2.00 copay per visit under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Physical Exams	Benefit covered at 100%. \$0 copay under Medicaid Choice. \$2.00 copay per visit under Medicaid FFS.	Covered, \$0 Copay
Podiatry, medically necessary	Benefit covered at 100%. \$0 copay under Medicaid Choice. \$2.00 copay per visit under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Chiropractic Care, Medicare-Covered	Not a covered benefit under Medicaid Choice or Medicaid FFS	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Outpatient Substance Abuse	Benefit covered at 100%. \$0 copay under Medicaid Choice. \$0 copay under Medicaid FFS.	Group therapy visit: 20% of the cost Individual therapy visit: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Outpatient Mental Health	Benefit Covered at 100% \$0 copay under Medicaid Choice. \$0 copay under Medicaid FFS.	Outpatient group therapy visit: 20% of the cost Outpatient individual therapy visit: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Physical Therapy, Occupational Therapy, Speech Therapy	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$4.00 copay for outpatient visit \$2.00 copay for Physician visit \$0 copay in therapy clinic or rehab agency under Medicaid FFS.	Physical therapy, Occupational therapy, and Speech therapy visit: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Ambulance	Benefit Covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS.	20% of the cost If you are admitted to the hospital, you do not have to pay for the ambulance services.
Emergency Care	Benefit Covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS, if determined an emergency; \$6.00 per visit if not non-emergency for Medicaid FFS.	20% of the cost (up to \$90) If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Urgent Care	Benefit Covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS; \$2.00 per visit if not part of an emergency room.	20% of the cost (up to \$65) If you are admitted to the hospital within 3 days, you do not have to pay your share of the cost for urgently needed services. See the “Inpatient Hospital Care” section of this booklet for other costs. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Outpatient Services/Surgery	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$4.00 copay per visit under Medicaid FFS.	Ambulatory surgical center: 20% of the cost Outpatient hospital: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Durable Medical Equipment Including Oxygen	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per day under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Prosthetic Devices	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per day under Medicaid FFS.	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Diabetes self-monitoring, training, nutrition therapy and supplies	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per visit under Medicaid FFS.	Therapeutic shoes or inserts: 20% of the cost Diabetic monitoring supplies: 20% of the cost Diabetes self-management training: \$0
Lab Services	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per date of service under Medicaid FFS.	20% of the cost for Medicare-covered lab services If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
X-Rays	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per date of service under Medicaid FFS.	0% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Diagnostic Radiology	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per date of service under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Therapeutic Radiology	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per date of service under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Bone Mass Measurement	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$1.00 copay per visit under Medicaid FFS.	Covered, \$0 Copay
Colorectal Screening	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$2.00 copay per visit for diagnostic or treatment colonoscopy. \$0 copay for screening under Medicaid FFS.	Covered, \$0 Copay
Immunizations	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$0 copay per visit under Medicaid FFS.	Covered, \$0 Copay
Mammograms	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$0 copay per visit under Medicaid FFS.	Covered, \$0 Copay
Pap Smears	Benefit Covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS.	Covered, \$0 Copay

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Prostate Cancer Screenings	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$0 copay under Medicaid FFS.	Covered, \$0 Copay
Renal Dialysis	Benefit Covered at 100%. \$0 copay under Medicaid Choice. Inpatient hospital, \$10 per date of service \$3.00 copay per visit \$0 copay for Dialysis Center/ Emergency under Medicaid FFS.	20% of the cost If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.
Part D Prescription Drugs - covered under Medicare	Medicaid benefits cover the following Medicare exclusions at 100%: Cough and Cold Products, Over-the-Counter Medications and certain allowed Prescription Vitamin and Mineral Products. \$0 copay under Medicaid Choice. \$3.00 for prescription or refill of brand name or generic prescription medicines.	\$435 Deductible Initial Coverage: Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> • A \$0 copay; or • A \$1.30 copay; or • A \$3.90 copay. For all other drugs, either 25% coinsurance <ul style="list-style-type: none"> • A \$0 copay; or • A \$3.60 copay; or • A \$8.95 copay. 'Extra Help' copay applies to Part D Prescription Drugs.

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Dental	<p>Medicaid benefits include: cleanings, fillings, root canals, crowns and partial dentures. \$0 copay.</p> <p>Adult dental benefit has an annual limit of \$1,500 per state fiscal year (July 1st - June 30th).</p> <p>Emergency and denture benefits are not subject to this limit.</p>	<p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover limited dental services, subject to Delta Dental Processing Policies, limitations, and exclusions. All claims are subject to dental consultant review:</p> <p>This information is not a complete description of the benefits. Limitations, copayments, and restrictions may apply.</p> <p>Please see the EOC, Chapter 4 pages 58-60 for complete description of the benefits.</p> <p>The Maximum Plan Benefit Coverage amount will be \$1,500 per year.</p>
Hearing Aids	<p>Benefit is covered at 100% under Medicaid Choice.</p> <p>\$0 copay under Medicaid Choice.</p> <p>Replacement of current cochlear implant if broken/lost.</p> <p>\$0 copay under Medicaid FFS.</p>	<p>Our plan pays up to \$1,000 every three years for hearing aids.</p>
Hearing Exams/Tests	<p>Benefits covered at 100%.</p> <p>\$0 copay under Medicaid Choice.</p> <p>\$2.00 copay per visit under Medicaid FFS.</p>	<p>Covered, \$0 Copay</p> <p>Exam to diagnose and treat hearing and balance issues: 20%</p> <p>If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay \$0.</p>

Benefit Category	Medicaid	Denver Health Medicare Choice (HMO D-SNP)
Eyewear	Benefit covered at 100% and \$0 copay under Medicaid Choice. Covered following eye surgery only and \$2.00 copay per visit under Medicaid FFS.	Our plan pays up to \$105 every year for contact lenses and/or eyeglasses (frames and lenses).
Eye Exams	Benefit Covered at 100%. \$0 copay under Medicaid Choice. \$2.00 copay per visit under Medicaid FFS.	Routine eye exam: \$0 copay every year
Transportation	Benefit covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS.	Covered, \$0 copay for up to 25 round trips
Health Club Membership	Not a covered benefit under Medicaid Choice or Medicaid FFS.	\$0 for membership to Denver Parks & Recreation Centers
Health/Wellness including smoking cessation, newsletters, health coaches/care management, nutritional training and Nursing Hotline	Benefit covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS.	Covered, \$0 copay
<p data-bbox="103 1157 527 1377">Interpreter Services</p> <p data-bbox="103 1230 527 1377">Interpreter services are available to help you get services. One interpretation is available for any language.</p> <ul data-bbox="175 1423 560 1549" style="list-style-type: none"> • Spoken language interpreter services. • Hearing interpreter services 	Benefit covered at 100%. \$0 copay under Medicaid Choice and Medicaid FFS.	Covered, \$0 Copay

Notice of Non-Discrimination

Denver Health Medical Plan, Inc., hereinafter referred to as the “Company,” complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, health status, or need for health care services.

The Company

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please contact the Company toll-free at 1-800-700-8140, for TTY please contact 711.

If you believe that the Company failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, health status, or need for health care services, you can file a grievance with the Company’s Grievance and Appeal Department at 938 Bannock Street, Mail Code 6000, Denver, CO 80204, telephone 303-602-2261. You can file a grievance by mail or telephone. If you need help filing a grievance, the Grievance and Appeal Specialist is available to help you.

You can also file a civil right complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
TDD: 800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-700-8140 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-700-8140 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-700-8140 (TTY:711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-700-8140 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-700-8140 (телетайп: 711).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ። 1-800-700-8140 (መስማት ለተሳናቸው: 711)።

لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 711). 1-800-700-8140

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-700-8140 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-700-8140 (ATS : 711).

ध्यानदिनुहोस्: तपाईंलेनेपालीबोलनुहुन्छभनेतपाईंकोनिम्तिभाषासह
ायतासेवाहरुनि:शुल्करूपमाउपलब्धछ।फोनगर्नुहोस् 1-800-700-8140 (टिटिवाइ: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-700-8140 (TTY: 711).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-700-8140 (TTY: 711) まで、お電話にてご連絡ください。

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-700-8140 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با 1-800-700-8140 (TTY: 711) تماس بگیرید.

Dè dẹ nìà kẹ dyédé gbo: Ọ jǔ kẹ̀ m̀ [Bàsòò-wùdù-po-nyò] jǔ ní, nìí, à wuḍu ká kò dọ̀ po-poò bẹ̀in m̀ gbo kpáa.
Ḍá 1-800-700-8140 (TTY: 711)

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-700-8140 (TTY: 711).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-700-8140 (TTY: 711).