Denver Health Medicare Select (HMO)

Summary of Benefits

January 1, 2020-December 31, 2020

DENVER HEALTH MEDICAL PLAN INC.™
Medicare Advantage

This information is not a complete description of benefits. Contact the plan for more information. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year. To get a complete list of services we cover, please request 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 Select (HMO))**.

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Denver Health Medicare Select (HMO**) 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 Select (HMO)**
- 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 users 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.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

Things to Know About Denver Health Medicare Select (HMO)

Denver Health Medical Plan, Inc. is a Medicare-approved HMO plan. Enrollment in a Denver Health Medical Plan, Inc. depends on contract renewal.

Hours of Operation

- From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.
- From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m.

Denver Health Medicare Select (HMO) 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?

To join **Denver Health Medicare Select (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Our service area includes the following counties in Colorado: **Adams, Denver, and Jefferson.**

Which doctors, hospitals, and pharmacies can I use?

Denver Health Medicare Select (HMO) 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 drugs.

You can see our plan's *Provider and Pharmacy* directories at 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?	
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
Our plan groups each medication into one of six "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier 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.	
How much is the monthly premium?	$31.30 per month. In addition, you must continue to pay your Medicare Part B premium.
How much is the deductible?	The Part B deductible for 2020 is $0. This means there is no deductible for hospital and medical services. The Part D deductible for 2020 is $250 for Part D prescription drugs except for drugs listed on Tier 1 and Tier 6, as these are specifically excluded from the deductible.
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. Your yearly limit(s) in this plan: • $5,500 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.
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: 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 per benefit period 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 per benefit period. In 2020, the amounts for each benefit periods are: Days 1-5: $300 per day, this will apply on day of discharge Days 6-90: $0 per day Days 91-150: $578 per lifetime reserve days *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	
Outpatient Hospital Services [1,2]	We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. 20% of the cost for each Medicare-covered outpatient hospital facility visit • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital *(You pay $0 for Medicare-covered lab services. Authorization rules DO NOT apply for Medicare-covered lab services*) • 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 screenings and preventive services • Certain drugs and biologicals that you can't give yourself *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." If you are not sure if you are an outpatient, you should ask the hospital staff.*
Surgery Center [1,2]	20% of the cost for Medicare-covered outpatient surgery services provided at ambulatory surgical centers.
Doctor's Office Visits [1,2]	Primary Care Visit: $0 copay Specialist Visit [1,2]: $35 copay

SECTION II - SUMMARY OF BENEFITS	
Preventive Care	You pay $0 Our plan covers many preventive services, including: • 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 *(Authorization rules apply.)* • Health and wellness education programs • HIV screening • Immunizations, including Flu shots, Hepatitis B shots, Pneumococcal shots • Lung cancer screening (LDCT) • Medical nutrition therapy services • Medicare Diabetes Prevention Program (MDPP) • 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 Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	$80 copay 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.
Urgently Needed Services	$40 copay 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.

SECTION II - SUMMARY OF BENEFITS	
Diagnostic Procedures/Tests/Lab Services; Diagnostic/Therapeutic Radiology Services *(Costs for these services may be different if received in an outpatient surgery setting)*[1,2]	Diagnostic tests and procedures: 20% of the cost Lab services: $0 *(Authorization rules DO NOT apply for Medicare-covered lab services.)* 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
Hearing Services	Exam to diagnose and treat hearing and balance issues: $35 copay Routine Hearing exam (for up to 1 every three years): $35 copay Hearing aid fitting/evaluation (for up to 1 every three years): $35 copay Hearing aids: Our plan pays up to $1,000 every three years for hearing aids.
Dental Services	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover the listed dental services, subject to Delta Dental Processing Policies, limitations, and exclusions. All claims are subject to dental consultant review: This information is not a complete description of the benefits. Limitations, copayments, and restrictions may apply. Please see the EOC, Chapter 4, pages 58-60 for complete description of the benefits.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $35 copay Routine eye exam (for up to 1 every year): $35 copay 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).

SECTION II - SUMMARY OF BENEFITS	
Mental Health Care 1,2	Inpatient Visit1,2: 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 per benefit period 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 per benefit period. *Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.* In 2020, the amounts for each benefit periods are: Days 1-5: $300 per day, this will apply on date of discharge Days 6-90: $0 per day Days 91-150: $578 per lifetime reserve days Outpatient Visit 2: Outpatient group therapy visit: $0 copay Outpatient individual therapy visit: $0 copay
Skilled Nursing Facility (SNF) 1,2	Our plan covers up to 100 days in a SNF In 2020, the amounts are: • You pay nothing for days 1 through 20 • $176 copay per day for days 21 through 100

SECTION II - SUMMARY OF BENEFITS	
Outpatient Rehabilitation [1,2]	Cardiac (heart) rehab services: 20% of the cost Pulmonary (lung) rehab services: 20% of the cost Occupational therapy visit: $35 copay Physical therapy visit: $10 copay Speech therapy visit: $10 copay
Ambulance	20% of the cost If you are admitted to the hospital, you do not have to pay for the ambulance services.
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
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 copay
Diabetes Supplies and Services [1]	Diabetic therapeutic shoes or inserts: 20% of the cost Diabetic supplies: $0 *Diabetic glucometers and test strips are limited to Trividia Health Product. Glucometers and test strips made by other manufactures require an organization determination*. Diabetes self-management training: $ 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: • 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]: $0 copay Individual therapy visit [2]: $0 copay
Opioid Treatment Services [2]	Group therapy visit: $0 Individual therapy visit: $0 Treatment medications: $0 Toxicology testing: $0

SECTION II - SUMMARY OF BENEFITS	
Outpatient Surgery [1,2]	Ambulatory surgical center: 20% of the cost Outpatient hospital: 20% of the cost
Prosthetic Devices *(braces, artificial limbs, etc.).* [1]	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost
Renal Dialysis [1,2]	20% of the cost
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. *You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.*

Prescription Drug Benefits	
Initial Coverage State	After you pay your yearly deductible of $250, you pay the following cost sharing as seen in the charts below until your total yearly drug costs reach $4,020. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. 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.

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$3 copay	$6 copay	$6 copay
Tier 2 (Generic)	$9 copay	$18 copay	$18 copay
Tier 3 (Preferred Brand)	25% coinsurance	25% coinsurance	25% coinsurance
Tier 4 (Non-Preferred Brand)	50% coinsurance	50% coinsurance	50% coinsurance
Tier 5 (Specialty Tier)	28% coinsurance	Not covered	Not covered
Tier 6 (Select Care Drug)	$0 copay	$0 copay	$0 copay

Standard Mail Order Cost-Sharing

Tier	One-month Supply	Three-month supply
Tier 1 (Preferred Generic)	Not covered	$6 copay
Tier 2 (Generic)	Not covered	$18 copay
Tier 3 (Preferred Brand)	Not covered	25% coinsurance
Tier 4 (Non-Preferred Brand)	Not covered	50% coinsurance
Tier 5 (Specialty Tier)	28% coinsurance	Not covered
Tier 6 (Select Care Drug)	Not covered	$0 copay

Prescription Drug Benefits	
Initial Coverage Stage Continued	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	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. 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 toll free at 1-877-956-2111. 711 for TTY users, or you can access our Evidence of Coverage online.
Catastrophic Coverage Stage	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: • 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. 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.denvermedicalplan.org.

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: 한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다.
1-800-700-8140 (TTY: 711) 번으로전화해주십시오.

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

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لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

1-800-700-8140 (رقم هاتف الصم والبكم :711).

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: तपाईलेनेपालीबोल्नुहुन्छभनेतपाईकोनिम्तिभाषासह
ायतासेवाहरूनिःशुल्करूपमाउपलब्धछ।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.

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Dè ɖɛ nià kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓέìn m̀ gbo kpáa. Đá 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).