DENVER HEALTH MEDICAL PLAN INC.
Medicare Advantage

Denver Health Medicare Choice (HMO D-SNP*) offered by* Denver Health Medical Plan, Inc.

Annual Notice of Changes for 2021

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

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 2021 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 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 medicare.gov/plan-compare website.
- 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 don't join another plan by December 7, 2020, you will be enrolled in Denver Health Medicare Choice (HMO D-SNP).
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 2.2, page 16 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2020**

- If you don't join another plan by **December 7, 2020**, you will be enrolled in Denver Health Medicare Choice (HMO D-SNP).
- If you join another plan between **October 15** and **December 7, 2020**, your new coverage will start on **January 1, 2021**. You will be automatically disenrolled from your current plan.

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.
- This document may be available in other formats such as braille, large print or other alternate formats.
- **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 irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Denver Health Medicare Choice (HMO D-SNP)

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

Summary of Important Costs for 2021

The table below compares the 2020 costs and 2021 costs for Denver Health Medicare Choice (HMO D-SNP) 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 denverhealthmedicalplan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 for your deductible, doctor office visits, and inpatient hospital stays.

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Monthly plan premium♦ ♦ Your premium may be higher or lower than this amount. See Section 2.1 for details.	$31.30	$34.30
Deductible**	$198	$198 These are 2020 cost-sharing amounts and may change for 2021. Denver Health Medicare Choice (HMO D-SNP) will provide updated rates as soon as they are released.
Doctor office visits**	Primary care visits: 20% of the cost per visit Specialist visits: 20% of the cost per visit	Primary care visits: 20% of the cost per visit Specialist visits: 20% of the cost per visit

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Inpatient hospital stays** 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**.**	$1,408 deductible for each benefit period. • Days 1-60: $0 copay for 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).	These are 2020 cost-sharing amounts and may change for 2021. $1,408 deductible for each benefit period. • Days 1-60: $0 copay for 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).

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $435 Copayment/Coinsurance during the Initial Coverage Stage: Generic Drugs (including brand drugs treated as generic, either): $0 copay; or $1.30 copay; or $3.60 copay; or 25% of the total cost. For all other drugs, either: $0 copay; or $3.90 copay; or $8.95 copay; or 25% of the total cost.	Deductible: $445 Copayment/Coinsurance during the Initial Coverage Stage: Generic Drugs (including brand drugs treated as generic, either): $0 copay; or $1.30 copay; or $3.70 copay; or 15% of the total cost. For all other drugs, either: $0 copay; or $4.00 copay; or $9.20 copay; or 15% of the total cost. **If you lose Low Income Subsidy you pay 25% of the cost for generic and non-generic drugs.**
Maximum out-of-pocket amount** This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$7,550

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Monthly premium** (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$31.30	$34.30

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	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays and deductibles) 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.	$6,700	$7,550 Once you have paid $7,550 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 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 2021 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 to manage 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.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at denverhealthmedicalplan.org. You may also call Health Plan Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

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, *Benefits Chart (what is covered and what you pay)*, in your *2021 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at denverhealthmedicalplan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage.*

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Acupuncture for chronic low back pain** Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	Acupuncture is not covered.	You pay 20% of the total cost for each Medicare covered acupuncture service.

Cardiac and Pulmonary Rehabilitation Services** Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services. SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a	If you are eligible for Medicare cost-sharing assistance under Medicaid, you will pay $0 for each Medicare-covered supervised exercise therapy visit as long as you meet the eligibility requirements. If you do not meet the eligibility requirements, you pay 20% of the cost for each supervised exercise therapy visit. *For a maximum of 2 one-hour sessions per day for up to 36 sessions up to 12 weeks. You may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time of deemed medically necessary by a health care provider.	*†You pay 20% of the total cost.

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Inpatient hospital stays** 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.	*†$1,408 deductible for each benefit period. • Days 1-60: $0 copay for 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).	*†These are 2020 cost-sharing amounts and may change for 2021. Denver Health Medicare Choice (HMO D-SNP) will provide updated rates as soon as they are released. $1,408 deductible for each benefit period. • Days 1-60: $0 copay for 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).

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Inpatient mental health care** • Covered services include mental health care services that require a hospital stay. • You get up to 190 days of inpatient psychiatric hospital care in a lifetime. • Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. o Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	*†$1,408 deductible for each benefit period. • Days 1-60: $0 copay for 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). 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.	*†These are 2020 cost-sharing amounts and may change for 2021. Denver Health Medicare Choice (HMO D-SNP) will provide updated rates as soon as they are released. $1,408 deductible for each benefit period. • Days 1-60: $0 copay for 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). 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.

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Skilled Nursing Facility**	*†If you are eligible for Medicare cost-sharing assistance under Medicaid, you will pay $0 for each Medicare-covered SNF stay as long as you meet the eligibility requirements. If you do not meet the eligibility requirements, you pay the following amounts for each Medicare-covered SNF stay: Our plan covers up to 100 days in a SNF. In 2020 the amounts for each benefit period are: • Days 1 – 20: $0 copay per day. • Days 21 – 100: $176 copay per day.	*†These are 2020 cost-sharing amounts and may change for 2021. Denver Health Medicare Choice (HMO D-SNP) will provide updated rates as soon as they are released. If you are eligible for Medicare cost-sharing assistance under Medicaid, you will pay $0 for each Medicare-covered SNF stay as long as you meet the eligibility requirements. If you do not meet the eligibility requirements, you pay the following amounts for each Medicare-covered SNF stay: Our plan covers up to 100 days in a SNF. In 2020 the amounts for each benefit period are: • Days 1 – 20: $0 copay per day. • Days 21 – 100: $176 copay per day.

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Hearing Services**	You pay 20% of the total cost for Medicare-covered hearing exams. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. You pay $0 for up to one supplemental hearing aid exam every three years. You pay $0 for fitting/evaluation for hearing aid. You are covered up to $1,000 for hearing aids (both ears combined) every three years.	You pay 20% of the total cost for Medicare-covered hearing exams. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. You pay $0 for up to one supplemental hearing aid exam every three years. You pay $0 for fitting/evaluation for hearing aid. You are covered up to $1,500 for hearing aids (both ears combined) every three years.
Transportation Services We cover round-trip medical transportation to in-network provider appointments.	†You pay $0 for up to 25 round trips to plan approved health-related locations each year.	You pay $0 for up to 35 round trips to plan approved health-related locations each year. No Prior Authorization Required.

Cost	2020 (this year)	2021 (next year)
* Your plan provider may need to provide a referral. † Prior Authorization may be required. **If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.		
Vision Care	*You pay 20% of the total cost for Medicare-covered eye exams. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. You pay $0 for up to one supplemental routine eye exam every year. You are covered up to $105 for contact lenses and/or 1 pair of eye glasses (lenses and frames) every year. Referral Required for Medicare-covered glaucoma screening.	You pay 20% of the total cost for Medicare-covered eye exams. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay a $0 copayment amount. You pay $0 for up to one supplemental routine eye exam every year. You are covered up to $200 for contact lenses and/or 1 pair of eye glasses (lenses and frames) every year. No referral required for Medicare-covered glaucoma screening.

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 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. Because you receive "Extra Help" and haven't received this insert by September 30, 2020, please call Health Plan Services and ask for the "LIS Rider."

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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2020 (this year)	2021 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Part D drugs until you have reached the yearly deductible.	Your deductible amount is either $0 or $435, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	Your deductible amount is either $0 or $445, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)

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	2020 (this year)	2021 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** 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: **Generic Drugs (including brand drugs treated as generic), either:** • You pay $0 per prescription; or • You pay $1.30 per prescription; or • You pay $3.60 per prescription; or • You pay 25% of the total cost. **For all other drugs:** • You pay $0 per prescription; or • You pay $3.90 per prescription; or • You pay $8.95 per prescription; or • You pay 25% of the total cost. **Once your total drug costs have reached $4,020, 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: **Generic Drugs (including brand drugs treated as generic), either:** • You pay $0 per prescription; or • You pay $1.30 per prescription; or • You pay $3.70 per prescription; or • You pay 15% of the total cost. **For all other drugs:** • You pay $0 per prescription; or • You pay $4.00 per prescription; or • You pay $9.20 per prescription; or • You pay 15% of the total cost. **If you lose Low Income Subsidy you pay 25% of the cost for generic and non-generic drugs.** **Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).**

Changes to the Coverage Gap and Catastrophic Coverage Stages

The Coverage Gap Stage and the Catastrophic Coverage Stage are two other drug coverage stages for people with high drug costs. **Most members do not reach either stage**.

For information about your costs in these stages, look at your *Summary of Benefits* or 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 Choice (HMO D-SNP)

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our Denver Health Medicare Choice (HMO D-SNP).

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 2021 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2021*, 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 medicare.gov/plan-compare. **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

As a reminder, Denver Health Medical Plan, Inc. offers another Medicare health plan which includes Medicare prescription drugs. 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 Choice (HMO D-SNP).

- 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 Choice (HMO D-SNP).
- 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 8.1 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.

  If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 3 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from October 15 to December 7. The change will take effect on January 1, 2021.

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.

If you enrolled in a Medicare Advantage plan for January 1, 2021, 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, 2021. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 4 Programs That Offer Free Counseling about Medicare and Medicaid

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 1-888-696-7213. You can learn more about Colorado State Health Insurance Assistance Program (Colorado SHIP) by visiting their website (colorado.gov/pacific/dora/ship-locations).

For questions about your Health First Colorado (Colorado's Medicaid Office) benefits, contact 1-800-221-3943, TTY call 711, Monday - Friday, 8 a.m.to 4:30 p.m., Saturday, 8 a.m. to 12 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Health First Colorado (Colorado's Medicaid Office) coverage.

SECTION 5 Programs That Help Pay for Prescription Drugs

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

- **"Extra Help" from Medicare.** Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, 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 am and 7 pm, Monday through Friday. TTY users should call, 1-800-325-0778 (applications); or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Colorado has a program called Colorado State Drug Assistance Program (SDAP) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Section 6 of this booklet).
- **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 303-692-2783 or 303-692-2716, TTY: 711, Monday - Friday, 8 a.m. to 5 p.m.

SECTION 6 Questions?

Section 6.1 – Getting Help from Denver Health Medicare Choice (HMO D-SNP)

Questions? We're here to help. Please call Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111. (TTY only, call 711.) We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free.

Read your 2021 *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 2021. For details, look in the 2021 *Evidence of Coverage* for Denver Health Medicare Choice (HMO D-SNP). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at denverhealthmedicalplan.org. You may also call Health Plan Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at denverhealthmedicalplan.org. 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 (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 medicare.gov/plan-compare).

Read *Medicare & You 2021*

You can read *Medicare & You 2021* 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 (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.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid you can call Health First Colorado (Medicaid) at 1-800-221-3943. TTY users should call 711.