ELEVATE MEDICARE ADVANTAGE
Denver Health Medical Plan Inc.™

Denver Health Medical Plan, Inc.

Elevate Medicare Select (HMO)

Adams, Denver or Jefferson County

Summary of Benefits

2022

January 1-December 31, 2022

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About this Summary of Benefits

Thank you for considering Denver Health Medical Plan, Inc. (DHMP) Medicare Advantage. You can use this **Summary of Benefits** to learn more about our plan. It includes information about:

- Premiums
- Benefits and costs
- Part D prescription drugs
- Who can enroll
- Coverage rules
- Getting care

For more details

This document is a summary. It doesn't include everything about what's covered and not covered or all the plan rules. For details, see the **Evidence of Coverage (EOC)**, which is located on our website at www.denverhealthmedicalplan.org or ask for a copy from Health Plan Services by calling 303-602-2111 or toll-free 1-877-956-2111, 8 a.m. to 8 p.m., seven days a week. For TTY users, call 711.

If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Out-of-network/non-contracted providers are under no obligation to treat Elevate Medicare Select (HMO) members, except in emergency situations. Please call our Health Plan Services number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

ATTENTION: If you speak Spanish, language assistance services are available to you at no cost. Please call our Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111. TTY should call 711. Our hours of operation are 8 a.m. to 8 p.m., seven days a week.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a nuestros Servicios del Plan de Salud al 303-602-2111 o sin costo al 1-877-956-2111. 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.

Who Can Enroll?

You are eligible to enroll for this plan if:

- You have both Medicare Part A and Part B.
- You are entitled to Part D.
- You must reside in Adams, Denver or Jefferson County.

What Do We Cover?

DHMP covers everything that Original Medicare covers – and more.

- Our plan members get all benefits covered by Original Medicare.
- Our plan members also get more than what is covered by Original Medicare. Some of the benefits are outlined in this booklet. For a full list of benefits, you can access our **EOC** online.

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

Coverage Rules

We cover the services and items listed in this document and the **EOC**, if:

- The services or items are medically necessary.
- The services or items are considered reasonable and necessary according to Original Medicare's standards.
- You get all covered services and items from the plan providers listed in our Provider Directory and Pharmacy Directory (there are exceptions to this rule). We also cover:
    - Emergency Care
    - Urgent Care
    - Out-of-Area Dialysis

For details about coverage rules, including services that are not covered (exclusions), see the **EOC**.

Getting Care

At most of our in-network facilities, you can usually get the covered services you need, including specialty care, pharmacy and lab work. To find our provider locations, see our Provider Directory online (www.denverhealthmedicalplan.org/find-doctor.org) or ask us to mail you a copy by calling Health Plan Services at 303-602-2111 or toll-free 1-877-956-2111, 8 a.m. to 8 p.m., seven days a week. For TTY, call 711.

Medicare Part C: What's covered and what it costs

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Monthly Plan Premiums	$39.80 per month, depending on your level of *Extra Help*.
Deductible	The Part B deducible is $0, and applies to in-network services. The Part D deductible is $0, and applies to prescription drugs.
Your Maximum Out-of-Pocket Responsibility Does not include Medicare Part D drugs. If you are eligible for Medicare cost-sharing assistance, you are not responsible for paying any costs toward the maximum out-of-pocket amount for covered Medicare Part A and Part B services.	$4,400
Inpatient Hospital Coverage*† Our plan covers 90 days per benefit period.	• Days 1 - 5: $300 copay per day of each benefit period. • Days 6 - 90: $0 copay per day of each benefit period. • Days 91 and beyond: $742 copay per "lifetime reserve day" (up to 60 days over your lifetime). †Prior authorization is required for all acute rehabilitation services.
Outpatient Hospital Coverage*	0% of the cost for colonoscopy/endoscopy; 20% of the cost for other services.
Ambulatory Surgery Center*	0% of the cost for colonoscopy/endoscopy; 20% of the cost for other services.
Doctor Office Visits	Primary Care Visit: $0 copay. Specialist Visit*: $20 copay.
Preventive Care	$0 copay. *See **EOC** for details.*
Emergency Care We cover emergency care anywhere in the United States.	$80 copay. If you are admitted to the hospital within 3 days, you pay $0 copay for the emergency room visit.
Urgently Needed Services	$20 copay. If you are admitted to the hospital within 3 days, you pay $0 copay for the emergency room visit.

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Diagnostic Services, Lab and Imaging* • Diagnostic tests and procedures • X-rays • Lab tests	20% of the cost for diagnostic tests, procedures and x-rays. $0 copay for lab tests.
Hearing Services • Exam to diagnose and treat hearing and balance issues • Routine hearing exams • Hearing aid fitting or evaluation exam • Hearing aids	$20 copay for Medicare-covered diagnostic hearing exams. $20 copay for up to one routine hearing exam and one evaluation for hearing aid every three years. Covered up to $1,500 allowance every 3 years for hearing aids (both ears combined) every three years.
Dental Services† Preventive and comprehensive dental coverage	$0 copay for limited dental services, subject to Delta Dental processing policies, limitations and exclusions. • Cleanings (up to 2 per calendar year) • Bitewing x-ray (1 set of 4 per calendar year) • Full mouth or panoramic x-ray (every 36 months) • Fluoride treatment (one treatment per year) • Fillings (up to 1 per tooth per 12 months. Multiple fillings on one surface will be paid as a single filling. Replacement of an existing amalgam filling is allowed if at least 12 months have passed since the existing amalgam was placed) *See **EOC** for details.*
Vision Services • Visits to diagnose and treat eye disease and conditions • Supplemental routine eye exam • Contact lenses and/or eyeglasses (frames and lenses)	$20 copay for visits related to Medicare-covered diagnosis and treatment for diseases and conditions of the eye. $20 copay for up to one supplemental routine eye exam every year. You are covered up to $250 for contact lenses and/or one pair of eye glasses (lenses and frames) every year. $0 copay for annual glaucoma screening for people at risk.

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Inpatient Mental Health Services*†	Our plan covers up to 90 days for each benefit period and up to 60 days over your 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. • Days 1-5: $0 copay. • Days 6-90: $0 copay. • Days 91 and beyond: $742 per lifetime reserve days.
Outpatient Mental Health Services* Outpatient group and individual therapy	$0 copay.
Skilled Nursing Facility (SNF)* Our plan covers up to 100 days per benefit period. A new benefit period begins after 60 days with no readmission for the same condition.	You pay: • Days 1-20: $0 copay. • Days 21-100: $194.50 copay per day.
Outpatient Rehabilitation* • Cardiac (Heart) • Pulmonary (Lung) • Occupational Therapy† • Physical Therapy† • Speech Therapy†	20% of the cost for each cardiac and pulmonary visit. $20 copay for each Medicare-covered occupational therapy visit. $10 copay for each Medicare-covered physical and speech therapy visit. †Prior authorization is required starting with the 31st visit for occupational, physical and speech therapy services.
Ambulance†	20% of the cost. If you are admitted to the hospital, you do not have to pay your share of the cost for the ambulance services. †Prior authorization is required for non-emergency Medicare-covered services and air ambulance.
Transportation Round-trip non-emergent medical transportation to plan approved health-related locations.	$0 copay for unlimited round-trips through Access2Care. †Prior authorization is only required for non-emergency air ambulance.

Benefits and Premiums	You Pay
* Referral required. † Your provider must obtain prior authorization from our plan.	
Medicare Part B Drugs †for non-preferred Part B drugs	20% of the cost.

Medicare Part D: Prescription Drug Coverage

Some individuals may be entitled to *Extra Help* from Medicare to pay for their prescription drug plan costs. Medicare provides *Extra Help* to help pay prescriptions for beneficiaries who have limited income and resources. If you'd like to learn more or need help applying, call our Sales Department at 303-602-2999.

Select Insulins are formulary insulins that are covered in Tier 2 and Tier 3 of our Drug List and are being used for a diagnosis covered under Part D. Please note that if your insulin is being administered through a Part B covered insulin pump then the insulin must be covered under Part B and will not be eligible for the Part D copay.

Initial Coverage Stage

- After you pay your yearly deductible of $0, you pay the following cost sharing as seen in the charts below until your yearly drug costs reach $4,430. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

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, including Select Insulins	$18 copay, including Select Insulins	$18 copay, including Select Insulins
Tier 3 Preferred brand	25% of the cost; $35 copay for Select Insulins	25% of the cost; $70 copay for Select Insulins	25% of the cost; $70 copay for Select Insulins
Tier 4 Non-preferred brand	50% of the cost	50% of the cost	50% of the cost
Tier 5 Specialty tier	33% of the cost	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, including Select Insulins
Tier 3 Preferred brand	Not covered	25% copay
Tier 4 Non-preferred brand	Not covered	50% copay
Tier 5 Specialty tier	33% of the cost	Not covered
Tier 6 Select care drug	Not covered	$0 copay

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 your drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

Coverage Gap Stage

The coverage gap stage is a temporary change in the cost for your prescription drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,430.

Elevate Medicare Select (HMO) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $9 or $18 or $35 or $70.

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 $7,050, which is the end of the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy, mail-order and through home delivery) reach $7,050, you pay the greater of:

- 5% of the cost; or
- $3.95 copay for generic (including brand drugs treated as generic) and a $9.85 copay for all other drugs.

For more information about these stages, call us at 303-602-2111 or toll-free 1-877-956-2111, call 711 for TTY users, or you can access our **EOC** online.

As a member of DHMP, you may get your drugs any of the following ways:

- **Retail Pharmacy**
  You can get a 30, 60, 90 or 100-day supply. For less than a month supply, please contact us at 303-602-2111.
- **Long Term Care (LTC) Pharmacy**
  LTC pharmacies must dispense brand name drugs in 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 us at 303-602-2111 if you have any questions about cost-sharing or billing when less than a one-month supply is dispensed.
- **Mail Order**
  Contact Health Plan Services at 303-602-2111 if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.

The plan uses a formulary, you can see the formulary at www.denverhealthmedicalplan.org, or call Health Plan Services at 303-602-2111 or toll-free at 1-877-956-2111 for a copy.

Additional Benefits	
Benefits	**You Pay**
* Referral required. † Your provider must obtain prior authorization from our plan.	
Chiropractic Care	$20 copay.
Diabetes Supplies and Services • Diabetes therapeutic shoes or inserts • Diabetic supplies • Diabetes self-management training	$0 copay for therapeutic shoes, inserts, diabetic monitoring supplies and diabetic self-management training. †Trividia Health diabetic testing supplies and Freestyle Libre continuous glucose monitoring system do not require authorization. All other vendors require prior authorization.
Over-the-Counter (OTC) Mail Order	Covered up to $150 every three months. Your allowance is available every quarter, starting January, April, July and October. The unused quarterly allowance will not carry over. You can view the catalogue and form at www.denverhealthmedicalplan.org/elevate-medicare-OTC. To order your product(s), mail or fax in the order form found on our web page. No returns, refunds or reimbursements accepted.