

**Summary of Benefits Report
Medicare Select (HMO)
January 1, 2010 – December 31, 2010
For Contract H5608, Plan 002**

Section I: Introduction to the Summary of Benefits

Thank you for your interest in Denver Health Medicare Select (HMO). Our plan is offered by Denver Health Medical Plan, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Denver Health Medicare Select (HMO) and ask for the "Evidence of Coverage."

YOU HAVE CHOICES IN YOUR HEALTH CARE.

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Denver Health Medicare Select (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Denver Health Medicare Select (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Denver Health Medicare Select (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS DENVER HEALTH MEDICARE SELECT (HMO) AVAILABLE?

The service area for this plan includes the following counties: Denver County, CO. You must live in this area to join the plan.

WHO IS ELIGIBLE TO JOIN DENVER HEALTH MEDICARE SELECT (HMO)?

You can join Denver Health Medicare Select (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End State Renal Disease are generally not eligible to enroll in Denver Health Medicare Select (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Denver Health Medicare Select (HMO) has formed a network of doctors, specialists and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

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You can ask for a current Provider Directory, or for an up-to-date list, visit us at <http://denverhealth.medicareplanrx.net>. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Denver Health Medicare Select (HMO) nor the Original Medicare Plan will pay for these services.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Denver Health Medicare Select (HMO) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Denver Health Medicare Select (HMO) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://denverhealth.medicareplanrx.net>. Our customer service number is listed at the end of this introduction.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Denver Health Medicare Select (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our member's ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://denverhealth.medicareplanrx.net>.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- * 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week.
- * The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or

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* Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Denver Health Medicare Select (HMO), you have the right to request a **coverage determination**, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Colorado Foundation for Medical Care. Telephone: 303/695-3300.

As a member of Denver Health Medicare Select (HMO), you have the right to request an **organization determination**, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Colorado Foundation for Medical Care. Telephone: 303/695-3300.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Denver Health Medicare Select (HMO) for more details.

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WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Denver Health Medicare Select (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

Plan Ratings - The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 720-956-2111 to obtain a copy of the plan ratings for this plan. TTY users call 720-956-2370.

Please call Denver Health Medical Plan for more information about Denver Health Medicare Select (HMO).

Visit us at www.denverhealth.org or, call us:

Member Service Hours:

We are available from 8:00 a.m. to 8:00 p.m. seven days a week.

Current and Prospective members should call toll free (877)-956-2111 for questions related to the Medicare Advantage and Prescription Drug Program. (TTY/TDD (877)-486-2048).

Current and Prospective members should call locally (720)-956-2111 for questions related to the Medicare Advantage and Prescription Drug Program. (TTY/TDD (720)-956-2370).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

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If you have any questions about this plan's benefits or costs, please contact Denver Health Medical Plan for details.

Section II – Summary of Benefits.

Benefit Category	Original Medicare	Denver Health Medicare Select (HMO)
IMPORTANT INFORMATION		
<p>1 – Premium and Other Important Information</p>	<p>In 2010, the monthly Part B Premium is \$ 96.40 and the yearly Part B deductible amount is \$155</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples).</p> <p>For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General</p> <p>\$ 31.00 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network</p> <p>In 2010, the yearly Part B Deductible amount is \$155. Contact the plan for services that apply.</p>

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<p>2 – Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network</p> <p>You must go to network doctors, specialists and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>
SUMMARY OF BENEFITS		
INPATIENT CARE		
<p>3 – Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services).</p>	<p>In 2010, the amounts for each benefit period are: Days 1 – 60: \$1,100 deductible. Days 61 – 90: \$275 per day. Days 91 – 150: \$550 per lifetime reserve day.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. This is no limit to the number of benefit periods you can have.</p>	<p>In-Network</p> <p>In 2010 the amounts for each benefit period are: Days 1 – 60: \$1,100 deductible Days 61 – 90: \$275 per day Days 91 – 150: \$550 per lifetime reserve day</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers 90 days each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4 – Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital</p>	<p>In-Network</p> <p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care”).</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p>

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		Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
<p>5 – Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 – 20: \$ 0 per day Days 21 – 100: \$137.50 per day</p> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay are: Days 1 – 20: \$ 0 per day. Days 21 – 100: \$137.50 per day</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p>
<p>6 – Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$0 copay for Medicare-covered home health visits.</p>
<p>7 – Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General</p> <p>You must get care from a Medicare-certified hospice.</p>

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OUTPATIENT CARE		
8 – Doctor Office Visits	20% coinsurance	<p>In-Network</p> <p>\$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>20% of the cost for each in-area, network urgent care Medicare-covered visit.</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits.</p>
9 – Chiropractic Services	<p>Routine care is not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>In-Network</p> <p>20% of the cost for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>
10 – Podiatry Services	<p>Routine care is not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network</p> <p>20% of the cost for each Medicare-covered visit.</p> <p>0% of the cost for up to 4 routine visit(s) every year.</p> <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p>
11 – Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	<p>In-Network</p> <p>20% of the cost for each Medicare-covered individual therapy visit.</p> <p>45% of the cost for each Medicare-covered group therapy visit.</p>

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12 – Outpatient Substance Abuse Care	20% coinsurance	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>20% of the cost for Medicare-covered individual or group visits.</p>
13 – Outpatient Services/Surgery	<p>20% coinsurance for the doctor.</p> <p>20% of outpatient facility charges.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>20% of the cost for each Medicare-covered ambulatory surgical center visit.</p> <p>20% of the cost for each Medicare-covered outpatient hospital facility visit.</p>
14 – Ambulance Services (medically necessary ambulance services)	20% Coinsurance	<p>In-Network</p> <p>20% of the cost for Medicare-covered ambulance benefits.</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>
15 – Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>20% of the cost (up to \$50) for Medicare-covered emergency room visits.</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p>

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		If you are admitted to the hospital within 3 day(s) for the same condition, you pay \$0 for the emergency room visit.
16 – Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay. NOT covered outside the U.S. except under limited circumstances.	General 20% of the cost for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 3 day(s) for the same condition, \$0 for the urgent care visit.
17 – Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered Occupational Therapy visits. 20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 – Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	General Authorization rules may apply. In-Network 20% of the cost for Medicare-covered items.

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<p>19 – Prosthetic Devices</p> <p>(includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>20% of the cost for Medicare-covered items.</p>
<p>20 – Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>In-Network</p> <p>20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p>
<p>21 – Diagnostic Tests, X-Rays, Lab Services, and Radiology Services.</p>	<p>20% coinsurance for diagnostic tests and x-rays.</p> <p>\$0 copay for Medicare-covered lab services.</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>20% of the cost for Medicare-covered X-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>

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PREVENTIVE SERVICES		
22 – Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network 20% of the cost for Medicare-covered bone mass measurement.
23 – Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	In-Network 20% of the cost for Medicare-covered colorectal screenings.
24 – Immunizations (Flu vaccine, Hepatitis B vaccine for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call you doctor for more information.	In-Network \$0 copay for Flu and Pneumonia vaccines. No referral needed for Flu and pneumonia vaccines. 20% of the cost for Hepatitis B vaccine.
25 – Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	In-Network 20% of the cost for Medicare-covered screening mammograms.
26 – Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	In-Network 0% of the cost for Medicare-covered pap smears. 20% of the cost for Medicare-covered pelvic exams.
27 – Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	In-Network 20% of the cost for Medicare-covered prostate cancer screening.

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28 – End-Stage Renal Disease	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-State Renal Disease.</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>20% of the cost for renal dialysis.</p> <p>20% of the cost for Nutrition Therapy for End-State Renal Disease.</p>
29 – Prescription Drugs	<p>Most drugs are not covered under Original Medicare.</p> <p>You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan, or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B.</p> <p>General</p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs Covered under Medicare Part D.</p> <p>General</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://denverhealth.medicareplanrx.net on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, <p>or</p>

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		<p>- have access to Indian/Tribal/Urban (Indian Health Service.)</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Denver Health Medicare Select (HMO) for certain drugs.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p>

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		<p>If you request a formulary exception for a drug and Denver Health Medicare Select (HMO) approves the exception, you will pay Tier II cost-sharing for that drug to reflect what is in your HPMS SB report.</p> <p>In-Network \$0 deductible. Initial Coverage You pay the following until total yearly drug costs reach \$2,830.</p> <p>Retail Pharmacy</p> <p>Tier I</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier. - \$21 copay for a three-month (90-day) supply of drugs in the tier. <p>Tier II</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs in this tier. - \$105 copay for a three-month (90-day) supply of drugs in this tier. <p>Tier III</p> <ul style="list-style-type: none"> - \$50 copay for a one-month (31-day) supply of drugs in this tier. - \$150 copay for a three-month (90-day) supply of drugs in this tier. <p>Long Term Care Pharmacy</p> <p>Tier I</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier.

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		<p>Tier II</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs in this tier. <p>Tier III</p> <ul style="list-style-type: none"> - \$50 copay for a one-month (31-day) supply of drugs in this tier. <p>Mail Order</p> <p>Tier I</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier. - \$21 copay for a three-month (90-day) supply of drugs in this tier. <p>Tier II</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs in this tier. - \$105 copay for a three-month (90-day) supply of drugs in this tier. <p>Tier III</p> <ul style="list-style-type: none"> - \$50 copay for a one-month (31-day) supply of drugs in this tier. - \$150 copay for a three-month (90-day) supply of drugs in this tier. <p>Coverage Gap</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p>

**Summary of Benefits Report
 Medicare Select (HMO)
 January 1, 2010 – December 31, 2010
 For Contract H5608, Plan 002**

Benefit Category	Original Medicare	Denver Health Medicare Select (HMO)
		<p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> - 5% coinsurance. <p>Out-of-Network</p> <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Denver Health Medicare Select (HMO).</p> <p>Out-of-Network Initial Coverage</p> <p>You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,830.</p> <p>Tier I</p> <ul style="list-style-type: none"> - \$7 copay for a (10-day) supply of drugs in this tier. <p>Tier II</p> <ul style="list-style-type: none"> - \$35 copay for a (10-day) supply of drugs in this tier.

**Summary of Benefits Report
Medicare Select (HMO)
January 1, 2010 – December 31, 2010
For Contract H5608, Plan 002**

Benefit Category	Original Medicare	Denver Health Medicare Select (HMO)
		<p>Tier III</p> <ul style="list-style-type: none"> - \$50 copay for a (10-day) supply of drugs in this tier. <p>Out-of-Network Coverage Gap</p> <p>After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Denver Health Medicare Select (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Denver Health Medicare Select (HMO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <ul style="list-style-type: none"> - A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, <p>or</p> <ul style="list-style-type: none"> - 5% coinsurance.
30 – Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - up to 1 oral exam(s) every year

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Benefit Category	Original Medicare	Denver Health Medicare Select (HMO)
Dental Services - continued		<ul style="list-style-type: none"> - up to 1 cleaning(s) every year - up to 1 dental x-ray(s) every year 20% of the cost for Medicare-covered dental benefits. Plan offers additional comprehensive dental benefits. \$1,300 limit for dental benefits every year.
31 – Hearing Services	<p>Routine hearing exams and hearing aids not covered</p> <p>20% coinsurance for diagnostic hearing exams</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered diagnostic hearing exams.</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> - up to 1 routine hearing test(s) every three years - up to 1 fitting-evaluation(s) for a hearing aid every three years <p>\$0 copay for hearing aids.</p> <p>\$1,500 limit for hearing aids every three years.</p>
32 – Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <p>\$0 copay for:</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery. - glasses - contacts - 20% of the cost for exams to diagnose and treat diseases and conditions of the eye. - 0% of the cost for up to 1 routine eye exam(s) every two years. <p>\$200 limit for eye wear every two years.</p>

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Benefit Category	Original Medicare	Denver Health Medicare Select (HMO)
33 – Physical Exams	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage.</p> <p>When you get Medicare Part B, you can get a one-time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network</p> <p>When you get Medicare Part B, you can get a one-time physical within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p> <p>Routine exams not covered.</p> <p>\$10 copay for Medicare-covered benefits.</p>
34 – Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p>In-Network</p> <p>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters. - Nutritional Training - Additional Smoking Cessation - Nursing Hotline <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p>
Transportation (Routine)	Not covered	<p>In-Network</p> <p>This plan does not cover routine transportation.</p>
Acupuncture	Not covered	<p>In-Network</p> <p>This plan does not cover Acupuncture.</p>