

# 2023 Summary of Benefits

## Health Partners Medicare (H9207)

### Health Partners Medicare Special (HMO SNP) (plan 004)

This is a summary of drug and medical services covered by Health Partners Medicare Special (HMO SNP) for the plan year January 1, 2023 - December 31, 2023.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of the services we cover, please see the *Evidence of Coverage*. View it online at [www.HPPMedicare.com](http://www.HPPMedicare.com) or get a copy by calling Member Relations at 1-866-901-8000 (TTY 1-877-454-8477). From **October 1 to March 31**, we're available 8 a.m. to 8 p.m., 7 days a week. And from **April 1 to September 30**, we're available 8 a.m. to 8 p.m., Monday to Friday.

This information is available for free in other languages. This document is available in other formats such as braille and large print. Please call Member Relations at 1-866-901-8000 (TTY 1-877-454-8477).

Health Partners Medicare has a network of doctors, hospitals, pharmacies and other providers. If you use providers that are not in our network, the plan may not pay for these services.

For information about prescription drugs covered, please see the plan's *Formulary*. For information about providers and pharmacies in our network, see our *Provider & Pharmacy Directory*. These documents are available at [www.HPPMedicare.com](http://www.HPPMedicare.com) or by calling the plan at 1-866-901-8000 (TTY 1-877-454-8477).

To join Health Partners Medicare Special, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be eligible for Medical Assistance (QMB+, SLMB+ or FBDE categories) from the Pennsylvania Department of Human Services and live in our service area. Our service area includes the following counties in Pennsylvania: Berks, Bucks, Carbon, Chester, Cumberland, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Montgomery, Northampton, Perry, Philadelphia and Schuylkill counties.

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](http://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.

Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal.

This information is not a complete description of benefits. Call 1-833-HPP-HPP3 (1-833-477-4773) for more information. From **October 1 to March 31**, we're available 8 a.m. to 8 p.m., 7 days a week. And from **April 1 to September 30**, we're available 8 a.m. to 8 p.m., Monday to Friday.

Premiums and prescription drug copayments, coinsurance, and deductibles may vary based on your eligibility for "Extra Help." Please contact the plan for further details.

**Important:** Enrollment in Health Partners Medicare Special is limited to Medicare beneficiaries who also are eligible for Medicaid categories QMB+, SLMB+ or FBDE. Cost-sharing amounts for medical services in the following benefit chart assume active eligibility. Should you lose Medicaid eligibility and choose to remain in the Special plan for up to six months while attempting to regain eligibility, Medicaid will not pay your Medicare cost-sharing and you will be responsible for these amounts. In this case, your cost-sharing will be no more than 20% coinsurance for most benefits. For additional information about cost-sharing during this period, please see the plan's Evidence of Coverage.

Even if you are otherwise eligible for 0% cost-sharing, remember that you generally must obtain services only from Health Partners Medicare providers who also participate in the Medical Assistance program; if not, Medical Assistance may not pay the provider and you will be responsible for the higher cost-sharing amount.

Please contact the Medical Assistance program for additional information about your level of cost-sharing.

**Prescription Drug Coverage Note:**

Members in the above Medicaid categories are automatically deemed to have eligibility for Medicare's Low Income Subsidy, also known as "Extra Help." The cost-sharing for prescription drugs in this Summary of Benefits assumes this eligibility.

Should you lose "Extra Help" and choose to remain in the Special plan, your costs will change. For additional information about cost-sharing in this situation, please call the plan.

	<b>Health Partners Medicare Special</b>
<b>Monthly plan premium</b>	<p>\$0</p> <p>Note: If your level of “Extra Help” changes, you may be responsible for a monthly premium up to \$41.10.</p> <p>You also must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.</p>
<b>Deductible</b>	<p>The Part B deductible is \$0.</p> <p>Note: If you lose Medicaid eligibility, you can remain in the plan for up to six months, but will be responsible for a Part B deductible of \$226.</p> <p>There is a \$0 deductible for prescription drugs while you receive “Extra Help.” If you lose eligibility for “Extra Help,” you may be responsible for up to a \$505 deductible.</p>
<p><b>Maximum out-of-pocket amount responsibility</b></p> <p><i>(does not include prescription drugs)</i></p>	<p>\$8,300 annually</p> <p>The most you pay for copay, coinsurance and other costs for medical services for the year.</p>

	<b>Health Partners Medicare Special</b>
<b>Outpatient Prescription Drugs (Part D)</b>	
	The plan covers up to a 90-day supply of covered drugs in-network through standard retail and mail order (or a 30-day supply through standard retail if out-of-network).
	\$0 for all Part D prescription drugs.
	While you receive “Extra Help,” you pay: \$0 for generic drugs \$0 for all other drugs Drugs noted as “non-extended day supply” in our plan Formulary are not available by mail order.
<b>Coverage Gap</b>	The Coverage Gap stage does not apply to you.
<b>Catastrophic Coverage</b>	If your total drug costs reach \$7,400, you will move to the Catastrophic Coverage stage and pay: \$0 for generic drugs \$0 for all other drugs
<b>Long-term care pharmacy and out-of-network pharmacy coverage</b>	Your costs for a 30-day supply at an out-of-network pharmacy or a 31-day supply from a long-term care pharmacy are the same as those for a 30-day supply at a standard retail pharmacy, as shown above. Extended supplies are not available from out-of-network or long-term care pharmacies. For more information, please see the plan’s <i>Evidence of Coverage</i> at <a href="http://www.HPPMedicare.com">www.HPPMedicare.com</a> or call us at 1-866-901-8000 (TTY 1-877-454-8477).

<b>Health Partners Medicare Special</b>	
<b>Medical Benefits (Part C)</b>	
<b>Inpatient hospital coverage★</b>	<p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>• \$0 deductible;</li> <li>• \$0 copay/coinsurance each day for days 1-60;</li> <li>• \$0 copay/coinsurance each day for days 61 to 90;</li> <li>• \$0 copay/coinsurance each day for days 91 and beyond (lifetime reserve days).</li> </ul> <p>Our plan covers up to 90 days for an inpatient hospital stay. Our plan also covers 60 “lifetime reserve days.” These are “extra” days that we cover. If your hospital stay is longer than 90 days, you can use these extra days.</p>
<b>Outpatient hospital coverage</b>	
Outpatient hospital visits★	\$0 copay/coinsurance
Outpatient hospital observation services	\$0 copay/coinsurance
<b>Ambulatory surgical center (ASC) services</b>	
Services provided at an ambulatory surgical center☆	\$0 copay/coinsurance
<b>Doctor visits</b>	
Primary Care Provider	\$0 copay/coinsurance
Specialists	\$0 copay/coinsurance
<b>Medicare-covered preventive care</b>	
Annual wellness exam	\$0 copay/coinsurance
Barium enemas	\$0 copay/coinsurance
Diabetes self-management training	\$0 copay/coinsurance

★ Prior authorization is required.

☆ Prior authorization may be required.

	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Medicare-covered preventive care (cont'd)</b>	
Digital rectal exams	\$0 copay/coinsurance
EKG following preventive services	\$0 copay/coinsurance
Glaucoma screening	\$0 copay/coinsurance
Other Medicare-covered preventive services	\$0 copay/coinsurance
<b>Emergency care</b>	\$0 copay/coinsurance
<b>Urgently needed services</b>	\$0 copay/coinsurance
<b>Diagnostic services/labs/imaging</b>	
<ul style="list-style-type: none"> <li>• Diagnostic tests and procedures★</li> <li>• Lab services</li> <li>• Advanced radiology services (such as MRI, PET, CT and nuclear medicine)★</li> <li>• Outpatient diagnostic imaging tests (such as x-rays, ultrasound and mammography)☆</li> <li>• Therapeutic radiology (such as radiation treatment for cancer)★</li> </ul>	\$0 copay/coinsurance for diagnostic services/labs/imaging
<b>Hearing services</b>	
Medicare-covered hearing exam	\$0 copay/coinsurance for Medicare-covered exam (limited to one every year)
Routine hearing exam	\$0 copay/coinsurance for routine hearing exam (limited to one every year)

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	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
Hearing aids	\$1,500 toward hearing aids every year
<b>Dental services</b>	
Preventive dental services	You pay \$0 copay/coinsurance for 2 exams and cleanings per year. x-rays covered (limits apply).
Medicare-covered dental services★  Supplemental comprehensive dental services★	\$0 copay/coinsurance for Medicare-covered dental services  Supplemental comprehensive dental services coverage (up to a maximum of \$3,500 per year) includes: <ul style="list-style-type: none"> <li>• Diagnostic services</li> <li>• Restorative services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Extractions</li> <li>• Prosthodontics</li> <li>• Oral/maxillofacial surgery</li> </ul>
<b>Vision care</b>	
Medicare-covered services include: <ul style="list-style-type: none"> <li>• Exam to diagnose and treat diseases and conditions of the eye</li> <li>• Eyewear after cataract surgery</li> </ul>	\$0 copay/coinsurance for Medicare-covered services
Routine eye exam	\$0 copay/coinsurance for Medicare-covered eyewear
Supplemental eyeglasses (frame and lenses) or contact lenses	\$0 copay/coinsurance for routine eye exam (limited to one every year)  \$0 copay/coinsurance for your choice of one of the following, up to \$500 yearly: <ul style="list-style-type: none"> <li>- one pair of eyeglasses (lenses and frames)</li> <li>- contact lenses up to the allowance</li> </ul>

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	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Mental health services</b>	
Inpatient psychiatric hospital coverage★	<p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>• \$0 deductible</li> <li>• \$0 copay/coinsurance for days 1-60</li> <li>• \$0 copay/coinsurance per day for days 61-90</li> <li>• \$0 copay/coinsurance each day for days 91 and beyond (lifetime reserve days).</li> </ul> <p>Our plan covers up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies).</p> <p>Our plan also covers 60 “lifetime reserve days.” If your hospital stay is longer than 90 days, you can use these extra days.</p>
Outpatient group therapy visit☆	\$0 copay/coinsurance
Outpatient individual therapy visit☆	\$0 copay/coinsurance
Psychiatric services☆	\$0 copay/coinsurance
Partial hospitalization★	\$0 copay/coinsurance per day
<b>Skilled nursing facility★</b>	<p>Days 1 to 20: \$0 copay/coinsurance per day</p> <p>Days 21 to 100: \$0 copay/coinsurance each day</p> <p>Our plan covers up to 100 days in a skilled nursing facility during each benefit period. (A benefit period begins the day you go into a hospital or skilled nursing facility. A new benefit period is available after 60 days in a row that you haven’t received any inpatient hospital care or skilled care in a SNF.)</p>

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	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Physical/occupational/speech &amp; language therapy ★</b>	\$0 copay/coinsurance
<b>Ambulance services</b> Ground Ambulance ☆ Air Ambulance ★	\$0 copay/coinsurance
<b>Transportation (routine)</b> Transportation is covered using taxi, rideshare services, van or medical transport. Members are required to coordinate trips with Health Partners Medicare's vendor at least two business days in advance. Mileage restrictions apply. See Evidence of Coverage for full details and restrictions related to benefit.	\$0 copay/coinsurance for unlimited one-way trips each year to plan-approved locations.
<b>Medicare Part B prescription drugs</b> Chemotherapy drugs ★ Other Part B drugs ☆	\$0 copay/coinsurance <b>Note:</b> Step therapy may apply for other Part B drugs.
<b>Acupuncture for chronic low back pain</b> Medicare-covered acupuncture for chronic low back pain  Supplemental acupuncture services	\$0 copay/coinsurance for each Medicare-covered visit for chronic low back pain. Up to 12 visits are covered during 90 days, and 8 additional visits during the year, subject to limitations and restrictions.  \$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year
<b>Cardiac rehabilitation services</b>	\$0 copay/coinsurance
<b>Chiropractic services ★</b> Medicare-covered services include: Manual manipulation of the spine to correct subluxation	\$0 copay/coinsurance

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	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Diabetic supplies</b> ☆ Members will be responsible for 20% coinsurance for non-preferred diabetic monitoring supplies if they do not provide their Medicaid or Community HealthChoices card at the pharmacy.	\$0 copay/coinsurance for diabetic monitoring supplies from preferred manufacturers \$0 copay/coinsurance for diabetic monitoring supplies from non-preferred manufacturers \$0 copay/coinsurance for all other Part B diabetic supplies
<b>Durable medical equipment (DME) and related supplies</b> ☆	\$0 copay/coinsurance
<b>Fitness program</b>	\$0 copay/coinsurance for SilverSneakers® membership or membership to the Salvation Army Kroc Center of Philadelphia.
<b>Home health care</b>	\$0 copay/coinsurance
<b>Meal benefit</b> Covers up to four weeks, once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or HPP clinical care coordinator.	\$0 copay/coinsurance for up to 28 days per year. Please contact the plan for more details.
<b>Opioid treatment program services</b>	\$0 copay/coinsurance for each opioid treatment service
<b>Over-the-counter (OTC) items</b> The benefit period corresponds to the quarters of the calendar year: 1st quarter: Jan. - March 2nd quarter: April - June 3rd quarter: July - Sept. 4th quarter: Oct. - Dec.	\$0 copay/coinsurance for up to \$305 every calendar quarter toward eligible OTC items. Unused amounts will not be rolled over from quarter to quarter. Allowance must be used for items for the member only.

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<b>Health Partners Medicare Special</b>	
<b>Medical Benefits (Part C)</b>	
<p><b>Podiatry services</b></p> <p>Medicare-covered services include:</p> <ul style="list-style-type: none"> <li>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Foot care for members with certain medical conditions affecting the lower limbs.</li> </ul> <p>Routine foot care, including corn/callus treatment, nail care and other preventive/maintenance care.</p>	<p>\$0 copay/coinsurance for Medicare-covered services</p> <p>\$0 copay/coinsurance for routine foot care (limited to one visit every three months)</p>
<b>Prosthetics/orthotics ★</b>	\$0 copay/coinsurance
<b>Pulmonary rehabilitation services</b>	\$0 copay/coinsurance
<p><b>Remote Access Technology (Teladoc®)</b></p> <p>Members have 24/7/365 access to credentialed doctors by phone or video. This service will not replace the role of the member's PCP and is a convenient option that allows members to talk to a doctor who can diagnose, recommend treatment and prescribe medication, when appropriate, for many non-emergent medical issues, including: bronchitis/sinus problems, allergies, cold and flu symptoms, respiratory infections and ear infections.</p>	\$0 copay/coinsurance for Teladoc services.
<p><b>Telehealth</b></p> <p>You have the option of receiving physician and certain other services either through an in-person visit or via telehealth using electronic audio-video technology. If you choose to receive one of these services via telehealth, then you must use a provider that is set up to provide the service through telehealth.</p>	<p>\$0 copay/coinsurance for these telehealth services:</p> <p>PCP services  Specialist services  Mental health specialty individual sessions  Psychiatric service individual sessions</p> <p>Note: Prior authorization is not required for the telehealth process. However, services that require authorization for in-person visits (including all out-of-network services) also require authorization when provided through telehealth.</p>

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<b>Health Partners Medicare Special</b>	
<b>Medical Benefits (Part C)</b>	
<p><b>Telemonitoring</b> An in-home telemonitoring program is covered for members who have congestive heart failure (CHF), hypertension or uncontrolled diabetes. Members will be provided clinical support while on the program through an application which allows chat, phone calls and video chat.</p> <p>In addition, blood pressure cuffs will be offered to members with uncontrolled hypertension. A doctor must recommend that a member needs these items. Limitations may apply.</p>	\$0 copay/coinsurance for telemonitoring services
<b>Worldwide emergency/urgent coverage</b>	\$0 copay/coinsurance up to \$5,000 maximum per year
<b>Value-Based Items and Services</b>	
<p><b>Food and produce</b> For eligible members (those with Medicare's Low Income Subsidy level 1, 2, 3 or 4), certain produce and other food items are covered. For these members, the plan's \$305 quarterly OTC allowance can also be used to purchase covered food and produce items. Unused amounts cannot be rolled over from one calendar quarter to another.</p> <p>Note: Health Partners Medicare offers the food and produce option through our participation in Medicare's Value-Based Insurance Design program. The food and produce option is not a Medicare- or plan-covered benefit.</p>	<p>\$0 copay/coinsurance for up to \$305 every calendar quarter toward covered produce and other food items. \$305 allowance applies to total food, produce and OTC purchases, and must be used for items for the member only.</p> <p>Please contact the plan for more details.</p>

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## Summary of Medicaid-Covered Benefits

To help you better understand your health care options, the following chart describes the costs for certain services as a Pennsylvania Medical Assistance (Medicaid) recipient and as a Health Partners Medicare Special member. To enroll in the Health Partners Medicare Special plan, you must be a full dual eligible, meaning that you qualify for both Medicare Part A and Part B and also receive full Medicaid benefits.

Medicare cost-sharing includes copayments, coinsurance and deductibles. As a full dual eligible member, your cost-sharing for Medicare Part A and B services is paid for you by the Medicaid program. This is reflected in the tables that follow. (Please see the Evidence of Coverage for details about your cost-sharing responsibility should you lose Medicaid eligibility and remain on this plan, which you may do for up to six months.)

Medicare coverage must be used first. Medicaid will then cover payment of your cost-sharing for Medicare Part A and Part B services.

**Medicaid will cover cost-sharing amounts only when your primary care doctor and other providers participate in the Medicaid program.** Both our print and online provider directories include information to help you choose network providers who also accept Medicaid. To help avoid errors, always show both your Health Partners Medicare member card and your Community HealthChoices and/or ACCESS card anytime you receive health care services.

It is important to know that Medicaid benefits and eligibility may change throughout the year. Please contact your Community HealthChoices plan, the Pennsylvania Medicaid program or your County Assistance Office for the most current and accurate information regarding your eligibility and benefits.

The benefits described in the preceding sections of the Summary of Benefits are covered by Health Partners Medicare Special. The benefits described in the following section are covered by Medicaid. For each benefit listed, you can compare what the Medical Assistance program covers and what our plan covers.

<b>Summary of Medicaid-Covered Benefits Adult Benefit Package</b>		
<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Primary Care visit</b>	No limits	\$0 copay/coinsurance for each Medicare-covered primary care visit
<b>Physician Services and Medical and Surgical Services provided by a Dentist</b>	No limits	<p>\$0 copay/coinsurance for each Medicare-covered specialist visit</p> <p>\$0 copay/coinsurance for Medicare-covered dental benefits</p> <p>\$0 copay/coinsurance for the following preventive dental benefits:</p> <ul style="list-style-type: none"> <li>• up to 2 oral exams every year</li> <li>• up to 2 cleanings every year</li> <li>• 1 set of dental x-rays every year</li> </ul> <p>\$3,500 plan coverage limit for supplemental comprehensive dental benefits every year</p>
<b>Certified Registered Nurse Practitioner</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit
<b>Federally Qualified Health Center/Rural Health Clinic</b>	No Limits except for Dental Care Services as described below	<p>\$0 copay/coinsurance for each Medicare-covered visit</p> <p>Also see Dental Care Services described below.</p>
<b>Independent Clinic</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Outpatient Hospital Clinic</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit
<b>Podiatrist Services</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit  \$0 copay/coinsurance for routine foot care visits (limited to one every three months)
<b>Chiropractor Services</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit
<b>Optometrist Services</b>	2 visits (exams) yearly	\$0 copay/coinsurance for each Medicare-covered visit (limited to one yearly)  \$0 copay/coinsurance for routine exam (limited to one yearly)
<b>Hospice Care</b>	The only key limitation is related to respite care, which may not exceed a total of five consecutive days in a 60-day certification period.	\$0 copay/coinsurance  (Hospice care is covered by Original Medicare.)
<b>Radiology (including x-ray, MRIs and CTs)</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered service

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Dental Care Services</b>	<p>Diagnostic, preventive, restorative, surgical dental procedures, prosthodontics and sedation</p> <p>Key Limitations:</p> <p>Dentures – one upper arch (complete or partial) and one lower arch (complete or partial) per lifetime</p> <p>Denture relines – either full or partial, limited to one arch every two calendar years</p> <p>Oral exams – one every 180 days</p> <p>Dental prophylaxis – one every 180 days</p> <p>Panoramic maxilla or mandible single film is limited to one every five calendar years.</p> <p>Crowns, periodontics and endodontics only with an approved benefit limit exception</p>	<p>\$0 copay/coinsurance for each Medicare-covered service</p> <p>\$0 copay/coinsurance for two oral exams and two cleanings yearly</p> <p>\$0 copay/coinsurance for x-rays (limits apply)</p> <p>\$3,500 allowance yearly for supplemental comprehensive dental services</p>
<b>Outpatient Hospital Short Procedure Unit (SPU)</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit
<b>Outpatient Ambulatory Surgical Center (ASC)</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered service



**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Non-Emergency Medical Transport</b>	Only to and from Medicaid-covered services	<p>\$0 copay/coinsurance for each Medicare-covered service</p> <p>\$0 copay/coinsurance for routine transportation to plan approved locations (unlimited one-way trips each year to plan-approved locations.)</p>
<b>Family Planning Clinic, Services and Supplies</b>	No Limits	Not covered
<b>Renal Dialysis</b>	<p>Initial training for home dialysis is limited to 24 sessions per patient yearly.</p> <p>Backup visits to the facility are limited to 75 visits yearly</p>	\$0 copay/coinsurance for each Medicare-covered visit
<b>Emergency Room</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered visit
<b>Ambulance (Emergency)</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered service

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Inpatient Acute Hospital or Inpatient Rehab Hospital</b>	No Limits	<p>Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days.</p> <p>The amounts for each inpatient stay are:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$0 deductible</li> <li>• Days 61–90: \$0 copay/coinsurance each day</li> <li>• \$0 copay/coinsurance each day</li> </ul> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Inpatient Psychiatric Hospital</b>	No Limits	<p>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.</p> <p>The amounts for each inpatient stay are:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$0 deductible</li> <li>• Days 61–90: \$0 copay/coinsurance each day</li> <li>• \$0 each day for up to 60 lifetime reserve days</li> </ul> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Inpatient Drug &amp; Alcohol</b>	No Limits	<p>Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. 190-day lifetime limit applies if stay is in a psychiatric hospital.</p> <p>The amounts for each inpatient stay are:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$0 deductible</li> <li>• Days 61–90: \$0 copay/coinsurance each day</li> <li>• \$0 copay/coinsurance each day for 60 lifetime reserve days</li> </ul> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<b>Maternity (Physician, Certified Nurse Midwives, Birth Centers)</b>	No Limits	\$0 copay/coinsurance for each Medicare-covered physician and certified nurse midwife service; birth centers not covered
<p><b>Mental Health and Substance Abuse (Behavioral Health) including:</b></p> <p><b>Outpatient Psychiatric Clinic, Mobile Mental Health Treatment, Outpatient Drug and Alcohol Treatment, Methadone Maintenance, Clozapine, Psychiatric Partial Hospital, Peer Support, Crisis, and Targeted Case Management.</b></p>	<p>No limits except:</p> <p>Targeted case management for behavioral health only is limited to individual with serious mental illness.</p> <p>Targeted case management for other than behavioral health is limited to individuals identified in the target group.</p>	<p>\$0 copay/coinsurance for each Medicare-covered individual therapy visit</p> <p>\$0 copay/coinsurance for each Medicare-covered group therapy visit</p> <p>Also see Prescription Drugs coverage below.</p>

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Prescription Drugs</b>	No Limits	<p>You pay the following during the Initial Coverage Period:</p> <ul style="list-style-type: none"> <li>• For generic drugs (including brand drugs treated as generic):               <ul style="list-style-type: none"> <li>○ \$0 copay/coinsurance</li> </ul> </li> <li>• For all other drugs:               <ul style="list-style-type: none"> <li>○ \$0 copay/coinsurance</li> </ul> </li> <li>• You can get drugs the following way(s):               <ul style="list-style-type: none"> <li>○ 1-month (30-day) supply</li> <li>○ 2-month (60-day) supply</li> <li>○ 3-month (90-day) supply</li> </ul> </li> </ul> <p>Note: Drugs noted in our plan formulary as “non-extended day supply” are not available as more than a 30-day supply.</p>
<b>Nutritional Supplements</b>	No Limits	\$0 copay/coinsurance when obtained through the plan’s Over-the-Counter benefit. \$305 quarterly allowance applies.

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Skilled Nursing Facility</b>	365 days covered yearly	Plan covers up to 100 days each benefit period No prior hospital stay is required. The amounts for each inpatient stay are: <ul style="list-style-type: none"> <li>• Days 1–20: \$0 copay/coinsurance each day</li> <li>• Days 21–100: \$0 copay/coinsurance each day</li> </ul>
<b>Home Health Care (includes nursing, nurse aide and therapy services)</b>	Unlimited for first 28 days. Limited to 15 days every month thereafter.	\$0 copay/coinsurance for Medicare-covered home health visits
<b>Intermediate Care Facility (ICF/IID and ICF/ORC)</b>	No limits but requires an institutional level of care.	Not covered
<b>Durable Medical Equipment</b>	No limits	\$0 copay/coinsurance for Medicare-covered durable medical equipment

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Prosthetics and Orthotics</b>	<p>Orthopedic shoes and hearing aids are not covered.</p> <p>Coverage of molded shoes is limited to molded shoes for severe foot and ankle conditions and deformities of such a degree that the beneficiary is unable to wear ordinary shoes without corrections and modifications.</p> <p>Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint.</p> <p>Coverage for low vision aids and eye prostheses is limited to one every two years.</p> <p>Coverage for an eye ocular is limited to one yearly.</p>	<p>\$1,500 hearing aid allowance yearly</p> <p>\$0 copay/coinsurance for Medicare-covered prosthetic devices, related medical supplies, and therapeutic shoes and inserts</p> <p>\$0 copay/coinsurance for other Medicare-covered items</p> <p>Low vision aids not covered</p>
<b>Eyeglasses and Contact Lenses</b>	<p>Eyeglasses limited to 4 lenses and 2 frames yearly for individuals diagnosed with aphakia. Deluxe frames not included</p> <p>Contact lenses limited to 4 lenses yearly for individuals diagnosed with aphakia.</p>	<p>\$0 copay/coinsurance for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery</p> <p>\$0 copay/coinsurance for supplemental eyewear (your choice of one of the following, up to \$500 yearly):</p> <ul style="list-style-type: none"> <li>- one pair of eyeglasses (lenses and frames)</li> <li>- contact lenses</li> </ul>

**Summary of Medicaid-Covered Benefits  
Adult Benefit Package**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Medical Supplies</b>	No limits	\$0 copay/coinsurance for Medicare-covered medical supplies
<b>Therapy (Physical, Occupational, Speech)</b>	Covered only when provided by a hospital, outpatient clinic or home health provider	\$0 copay/coinsurance for Medicare-covered physical therapy, occupational therapy and speech and language therapy visits
<b>Laboratory Services</b>	No limits	\$0 copay/coinsurance for Medicare-covered lab services
<b>Tobacco Cessation</b>	70 15-minute units covered yearly	Two counseling quit attempts covered yearly



**Summary of Medicaid-Covered Benefits  
Home and Community-Based Services**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<p><b>Adult Daily Living Services</b>  <b>Assistive Technology</b>  <b>Behavior Therapy</b>  <b>Benefits Counseling</b>  <b>Career Assessment</b>  <b>Cognitive Rehabilitation Therapy</b>  <b>Community Integration</b>  <b>Community Transition Services</b>  <b>Counseling</b>  <b>Employment Skills Development</b>  <b>Home Adaptations</b>  <b>Home Delivered Meals</b>  <b>Home Health Aide</b>  <b>Home Health – Nursing</b>  <b>Home Health – Occupational Therapy</b>  <b>Home Health – Physical Therapy</b>  <b>Home Health – Speech and Language Therapy</b>  <b>Job Coaching</b>  <b>Job Finding</b>  <b>Non-Medical Transportation</b>  <b>Nutritional Counseling</b>  <b>Participant-Directed Community Supports</b>  <b>Participant-Directed Goods and Services</b>  <b>Personal Assistance Services</b>  <b>Personal Emergency Response System</b>  <b>Pest Eradication</b>  <b>Residential Habilitation</b>  <b>Respite</b>  <b>Service Coordination</b>  <b>Specialized Medical Equipment and Supplies</b></p>	<p>Under Community Integration:  Each distinct goal may not be more than 26 weeks.  No more than 32 units a week for one goal will be approved. If the participant has multiple goals, no more than 48 units a week will be approved.  (The Office of Long Term Living retains the discretion to authorize more than 48 units (12 hours) of Community Integration in one week. Up to 21 hours a week and periods longer than 26 weeks may be authorized.)  Community Transition Services are limited to a combined \$4,000 per participant, per lifetime, as preauthorized by the State Medicaid Agency program office.  Total combined hours for Employment Skills Development or Job Coaching services are limited to 50 hours in a calendar week. Prior approval is required to exceed this limit.  Under Specialized Medical Equipment and Supplies, non-covered items include:  All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream).  Items covered under third party payer liability.</p>	<p>Home Delivered Meals covered up to four weeks (28 days), once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or HPP clinical care coordinator.  See Adult Benefit Package section above for coverage information about these benefits:</p> <ul style="list-style-type: none"> <li>• Home Health Care</li> <li>• Non-Emergency Medical Transport</li> <li>• Durable Medical Equipment</li> <li>• Medical Supplies</li> </ul> <p>Other services listed are not covered.</p>

**Summary of Medicaid-Covered Benefits  
Home and Community-Based Services**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<p><b>Structured Day Habilitation</b> <b>TeleCare</b> <b>Vehicle Modifications</b></p>	<p>Items that do not provide direct medical or remedial benefit and/or are not directly related to a participant's disability.</p> <p>Food, food supplements, food substitutes (including formulas) and thickening agents.</p> <p>Eyeglasses, frames and lenses.</p> <p>Dentures.</p> <p>Any item that is experimental or has been denied by Medicare and/or Medicaid.</p> <p>Recreational or exercise equipment and adaptive devices for them.</p>	

<b>Summary of Medicaid-Covered Benefits  Supplemental Benefits  (not covered by Original Medicare)</b>		
<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Acupuncture</b>	Not covered	\$0 copay/coinsurance for each supplemental acupuncture visit, limited to 20 visits each year.
<b>Dental</b>	See Dental Care Services in earlier Adult Benefit Package section for coverage details.	<p>\$0 copay/coinsurance for two oral exams and two cleanings yearly</p> <p>\$0 copay/coinsurance for x-rays (limits apply)</p> <p>\$3,500 allowance yearly for supplemental comprehensive dental services</p>
<b>Fitness</b>	Not covered	\$0 copay/coinsurance for SilverSneakers® fitness program membership
<b>Food and Produce</b>	Covered through the Supplemental Nutrition Assistance Program (SNAP) if eligible	\$305 quarterly allowance (in combination with Over-the-Counter benefit) for members eligible based on having Medicare's Low Income Subsidy level 1, 2, 3 or 4 (unused amounts cannot be carried over from one calendar quarter to another)
<b>Hearing</b>	Not covered	<p>\$0 copay/coinsurance for one routine hearing exam yearly</p> <p>\$1,500 hearing aid allowance yearly</p>
<b>Meals</b>	Not covered	\$0 copay/coinsurance for home-delivered meals for up to four weeks (28 days), once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by a physician, non-physician practitioner or HPP clinical care coordinator.
<b>Podiatry (Routine)</b>	No limits	\$0 copay/coinsurance for each visit (limited to one visit every three months)

<b>Summary of Medicaid-Covered Benefits  Supplemental Benefits  (not covered by Original Medicare)</b>		
<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Over-the-Counter Items</b>	Not covered	\$305 quarterly allowance (unused amounts cannot be carried over from one calendar quarter to another)
<b>Transportation (Routine)</b>	Available through Medical Assistance Transportation Program	\$0 copay/coinsurance for unlimited one-way trips each year to plan-approved locations.
<b>Vision Care</b>	<p>Two exams covered yearly</p> <p>Eyeglasses and contacts limited to individuals diagnosed with aphakia (up to two frames and four lenses or four contact lenses yearly)</p>	<p>\$0 copay/coinsurance for one routine exam yearly</p> <p>\$0 copay/coinsurance for supplemental eyewear (your choice of one of the following, up to \$500 yearly):</p> <ul style="list-style-type: none"> <li>• One pair of eyeglasses (lenses and frames)</li> <li>• Contact lenses</li> </ul>

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to Member Relations at 1-866-901-8000 (TTY 1-877-454-8477).

### Understanding the Benefits

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [www.HPPMedicare.com](http://www.HPPMedicare.com) or call 1-866-901-8000 (TTY 1-877-454-8477) to view a copy of the EOC.
- Review the *Provider & Pharmacy Directory* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the *Provider & Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums and/or copayments/coinsurance may change on January 1, 2024.
- Except in an emergency or urgent situation, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider & Pharmacy Directory*).
- This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. You must have **full** Medicaid health coverage to enroll.