Health Partners Medicare Complete (HMO-POS) offered by Health Partners Medicare

Annual Notice of Changes for 2023

You are currently enrolled as a member of Health Partners Medicare Complete (HMO-POS). Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.HPPMedicare.com. You may also call Member Relations to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK:** Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.
- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2022, you will stay in Health Partners Medicare Complete (HMO-POS).
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Health Partners Medicare Complete (HMO-POS).
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Relations number at 1-866-901-8000 for additional information. (TTY users should call 1-877-454-8477.) Hours are 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30.
- You can also request this information in alternate formats (such as braille, large print or audio) by calling Member Relations at 1-866-901-8000 (TTY users should call 1-877-454-8477).
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Health Partners Medicare Complete (HMO-POS)

- Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal.
- When this document says "we," "us," or "our," it means Health Partners Medicare. When it says "plan" or "our plan," it means Health Partners Medicare Complete (HMO-POS).

Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Health Partners Medicare Complete (HMO-POS) in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Deductible	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	$7,550	$7,900
Doctor office visits	Primary care visits: $0 per visit. Specialist visits: $30 per visit.	Primary care visits: $0 per visit. Specialist visits: $25 per visit.
Inpatient hospital stays	For Medicare-covered hospital stays: $200 copay per day for days 1 through 7 $0 copay per day for days 8 through 90 After day 90, $704 copay per lifetime reserve day (up to 60 days over your lifetime) for each inpatient stay.	For Medicare-covered hospital stays: $230 copay per day for days 1 through 5 $0 copay per day for days 6 through 90. After day 90, $704 copay per lifetime reserve day (up to 60 days over your lifetime) for each inpatient stay.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copay / Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $10 copay • Drug Tier 3: $47 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% coinsurance	Deductible: $0 Copay / Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 copay • Drug Tier 2: $10 copay • Drug Tier 3: $47 copay • Drug Tier 4: $100 copay • Drug Tier 5: 33% coinsurance
Senior Savings Program	Program not offered	Select Insulins: $10 copay

To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by their inclusion on the Drug List; all insulins listed are being covered as Select Insulins. If you have questions about the Drug List, you can also call Member Relations. (Phone numbers for Member Relations are printed on the back cover of this booklet).

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium There is no change to your plan premium for the upcoming benefit year. (You must also continue to pay your Medicare Part B premium.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay "out-of-pocket" for the year. This limit is called the "maximum out-of-pocket amount." Once you reach this amount, you generally pay nothing for covered services for the rest of the year.

Cost	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$7,550 This maximum does not include cost-sharing paid for services provided using the plan's point-of-service option.	$7,900 Once you have paid $7,900 out-of-pocket for covered services, you will pay nothing for your covered services for the rest of the calendar year. This maximum includes cost-sharing paid for services provided using the plan's point-of-service option.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.HPPMedicare.com. You may also call Member Relations for updated provider and/or pharmacy information or to ask us to mail you a directory.

There are changes to our network of providers for next year. **Please review the 2023 *Provider & Pharmacy Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2023 *Provider & Pharmacy Directory* to see which pharmacies are in our network.**

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Relations so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Cardiac Services	You pay a $50 copay for each visit for cardiac/intensive cardiac services or 20% coinsurance for out-of-network providers.	You pay a $40 copay for each visit for cardiac/intensive cardiac services or 20% coinsurance for out-of-network providers.
Inpatient Hospital	You pay: Days 1-7: $200 copay Days 8-90: $0 copay Days 90+: $704 copay for each lifetime reserve day, up to 60 days over your lifetime.	You pay: Days 1-5: $230 copay Days 6-90: $0 copay Days 90+: $704 copay for each lifetime reserve day, up to 60 days over your lifetime.

Cost	2022 (this year)	2023 (next year)
Inpatient Psychiatric Hospital	You pay: Days 1-7: $210 copay Days 8-90: $0 copay Days 90+: $0 copay for each lifetime reserve day, up to 60 days over your lifetime.	You pay: Days 1-5: $230 copay Days 6-90: $0 copay Days 90+: $0 copay for each lifetime reserve day, up to 60 days over your lifetime.
Mental Health Specialty Services	You pay a $30 copay for each Medicare-covered individual or group session or 20% coinsurance for out-of-network providers.	You pay a $25 copay for each Medicare-covered individual or group session or 20% coinsurance for out-of-network providers.
Opioid Treatment Services	You pay a $30 copay for each visit or 20% coinsurance for out-of-network providers.	You pay a $25 copay for each visit or 20% coinsurance for out-of-network providers.
Other Health Care Professional Services	You pay a $0 copay if provided in PCP office and a $30 copay if provided in specialist office or 20% coinsurance for out-of-network providers.	You pay a $0 copay if provided in PCP office and a $25 copay if provided in specialist office or 20% coinsurance for out-of-network providers.
Outpatient Substance Abuse	You pay a $30 copay for individual or group sessions.	You pay a $25 copay for individual or group sessions.
Podiatry	You pay a $30 copay for each Medicare-covered visit or 20% coinsurance for out-of-network providers.	You pay a $25 copay for each Medicare-covered visit or 20% coinsurance for out-of-network providers.

Cost	2022 (this year)	2023 (next year)
Psychiatric Services	You pay a $30 copay for Medicare-covered individual and group sessions or 20% coinsurance for out-of-network providers.	You pay a $25 copay for Medicare-covered individual and group sessions or 20% coinsurance for out-of-network providers.
Pulmonary Rehabilitation Services	You pay a $30 copay for each visit or 20% coinsurance for out-of-network providers.	You pay a $20 copay for each visit or 20% coinsurance for out-of-network providers.
Specialist Office Visits	You pay a $30 copay for each visit or 20% coinsurance for out-of-network providers.	You pay a $25 copay for each visit or 20% coinsurance for out-of-network providers.
Telehealth	You pay a $0 copay for PCP services, a $30 copay for specialist services and a $30 copay for mental health specialty and psychiatric sessions.	You pay a $0 copay for PCP services, a $25 copay for specialist services and a $25 copay for mental health specialty and psychiatric sessions.
Telemonitoring	Prior authorization is required for covered telemonitoring services.	Prior authorization is not required for covered telemonitoring services.
Vision care	You are covered up to $200 yearly for one pair of eyeglasses (lenses and frame), or contact lenses.	You are covered up to $250 yearly for one pair of eyeglasses (lenses and frame), or contact lenses.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is provided electronically.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions**.

In 2023 we will cover Select Insulins at a lower cost-sharing. To find out which drugs are Select Insulins, review the most recent Drug List we provided electronically. You can identify Select Insulins by their inclusion on the Drug List; all insulins listed are being covered as Select Insulins. If you have questions about the Drug List, you can also call Member Relations (phone numbers for Member Relations are printed on the back cover of this document).

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Relations for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you**. We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2022, please call Member Relations and ask for the "LIS Rider."

There are four "drug payment stages." The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Drug Tier 1 (Preferred Generic):** You pay $0 per prescription. **Drug Tier 2 (Generic):** You pay $10 per prescription. **Drug Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $47 per prescription for insulins. **Drug Tier 4 (Non-Preferred Drug):** You pay $100 per prescription.	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Drug Tier 1 (Preferred Generic):** You pay $0 per prescription. **Drug Tier 2 (Generic):** You pay $10 per prescription. **Drug Tier 3 (Preferred Brand):** You pay $47 per prescription. You pay $10 per prescription for Select Insulins. **Drug Tier 4 (Non-Preferred Drug):** You pay $100 per prescription.

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)	**Drug Tier 5 (Specialty Tier):** You pay 33% of the total cost. Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage). Health Partners Medicare Complete (HMO-POS) does not offer additional gap coverage for Select Insulins.	**Drug Tier 5 (Specialty Tier):** You pay 33% of the total cost. Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage). Health Partners Medicare Complete (HMO-POS) offers additional gap coverage for Select Insulins. During the Coverage Gap stage, your out-of-pocket costs for Select Insulins will be $10 for a one-month supply.

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call Member Relations for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048.

Additional Resources to Help – Please contact our Member Relations number at 1-866-901-8000 for additional information. (TTY users should call 1-877-454-8477.) Hours are 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30.

SECTION 2 Administrative Changes

	2022 (this year)	2023 (next year)
Member Relations Hours of Operation	Call 1-866-901-8000 (TTY 1-877-454-8477) 24 hours a day, seven days a week.	Call 1-866-901-8000 (TTY 1-877-454-8477), 8 a.m. – 8 p.m., seven days a week, October 1 – March 31; 8 a.m. – 8 p.m., Monday – Friday, April 1 – September 30.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Health Partners Medicare Complete (HMO-POS)

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

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR* -- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Health Partners Medicare offers other Medicare health plans and Medicare prescription drug plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Health Partners Medicare Complete (HMO-POS).
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from Health Partners Medicare Complete (HMO-POS).
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Member Relations if you need more information on how to do so.
  - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2023, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Pennsylvania, the SHIP is called Pennsylvania Medicare Education and Decision Insight (PA MEDI).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. PA MEDI counselors can help you with your

Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call PA MEDI at 1-800-783-7067. You can learn more about PA MEDI by visiting their website (www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx).

SECTION 6 Programs That Help Pay for Prescription Drugs

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

- "**Extra Help**" **from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Pennsylvania has a program called Pharmaceutical Assistance Contract for the Elderly (PACE) that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the State Pharmaceuticals Benefit Program (SPBP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-922-9384.

SECTION 7 Questions?

Section 7.1 – Getting Help from Health Partners Medicare Complete (HMO-POS)

Questions? We're here to help. Please call Member Relations at 1-866-901-8000. (TTY only, call 1-877-454-8477.) We are available for phone calls 8 a.m. - 8 p.m., 7 days a week, Oct. 1 - March 31 and Monday - Friday, April 1 - Sept. 30. Calls to these numbers are free.

Read your 2023 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the 2023 *Evidence of Coverage* for Health Partners Medicare Complete (HMO-POS). The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.HPPMedicare.com. You may also call Member Relations to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.HPPMedicare.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider & Pharmacy Directory*) and our list of covered drugs (Formulary/Drug List).

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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