



**Your  
health.  
Our  
focus.**

**2020 Summary of Benefits  
Health Partners Medicare Special  
(HMO SNP)**



**Health Partners** Plans

# 2020 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, 2020 - December 31, 2020.

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), 24 hours a day, seven days a week.

This information is available for free in other languages. This document is available in other formats such as Braille and large print. Please call our Member Relations number at 1-866-901-8000 (TTY 1-877-454-8477), 24 hours a day, seven days a week.

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). You can call 24 hours a day, seven days a week.

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, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Northampton, Perry and Philadelphia 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 <https://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) (TTY 1-877-454-8477) for more information.

Premiums and prescription drug copayments, coinsurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.

**Important:** Throughout the following benefit chart, where two cost-sharing amounts are shown for the same benefit, your cost-sharing will depend on your Medical Assistance (Medicaid) category. For example, “0% or 20%” indicates that you will pay 0% if you are in a Medical Assistance category that covers payment of the applicable Medicare cost-sharing amounts, and you will pay 20% if you are in a Medical Assistance category that does not cover payment of these cost-sharing amounts.

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.

	<b>Health Partners Medicare Special</b>
<b>Monthly plan premium</b>	You pay \$0 or \$35.60 depending on your level of “Extra Help.” You must continue to pay your Medicare Part B premium (unless it is paid for you by Medicaid).
<b>Deductible</b>	The Part B deductible is \$0 or \$198. There is a \$0 deductible for prescription drugs if you receive full Extra Help, or up to a \$435 deductible if you do not.
<b>Maximum out-of-pocket amount responsibility</b> <i>(does not include prescription drugs)</i>	\$3,400 annually The most you pay for copays, coinsurance and other costs for medical services for the year.

		<b>Health Partners Medicare Special</b>
<b>Outpatient Prescription Drugs (Part D)</b>		
	<b>Standard retail cost-sharing</b> (in-network) (up to a 30-day supply)	<b>Mail order cost-sharing</b> (up to a 90-day supply)
<b>Deductible</b>	\$0 for all Part D prescription drugs if you receive full Extra Help; up to \$435 if you do not.	
<b>Cost-sharing for covered drugs</b>	<p>If you receive full Extra Help you pay:</p> <p>\$0 or \$1.30 or \$3.60 for generic drugs \$0 or \$3.90 or \$8.95 for all other drugs</p> <p>If you do not receive full Extra Help, you will pay no more than 25% coinsurance.</p>	<p>If you receive full Extra Help you pay:</p> <p>\$0 or \$1.30 or \$3.60 for generic drugs \$0 or \$3.90 or \$8.95 for all other drugs</p> <p>If you do not receive full Extra Help, you will pay no more than 25% coinsurance. Specialty drugs are not available by mail order.</p>
<b>Coverage Gap</b>	If you receive Extra Help, the Coverage Gap Stage does not apply to you. If you do not receive Extra Help, after your total drug costs (including what our plan has paid and what you have paid) reach \$4,020, you will pay no more than 25% coinsurance for brand name and generic drugs during the coverage gap.	
<b>Catastrophic Coverage</b>	<p>After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$6,350, you pay \$0 if you receive full Extra Help.</p> <p>If you do not receive full Extra Help you pay the greater of:</p> <ul style="list-style-type: none"> <li>• 5% coinsurance, or</li> <li>• \$3.60 copayment for generics (including brand drugs treated as generic) and a \$8.95 copayment for all other drugs.</li> </ul>	
<b>Long-term care pharmacy and out-of-network pharmacy coverage</b>	Your costs may vary in long-term care or home infusion settings. 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). You can call 24 hours a day, a week.	

<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 or \$1,408 deductible;</li> <li>• \$0 copayment each day for days 1-60;</li> <li>• \$352 copayment each day for days 61 to 90;</li> <li>• \$704 copayment each day for days 91 to 150 (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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>All elective inpatient admissions require prior authorization. All other admissions will be reviewed for medical necessity and authorization.</p> <p>A deductible and/or other cost-sharing is charged for each inpatient stay.</p>
<b>Outpatient hospital coverage</b>	
Outpatient hospital visits	0% or 20% coinsurance
Outpatient hospital observation services	0% or 20% coinsurance
Services provided at an ambulatory surgical center	0% or 20% coinsurance
	<i>Prior authorization is required for outpatient hospital visits and ambulatory surgical center visits.</i>
<b>Doctor visits</b>	
Primary Care Providers	0% or 20% coinsurance
Specialists	0% or 20% coinsurance

	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Medicare-covered preventive care</b>	
Glaucoma screening	\$0 copayment
Diabetes self-screening	\$0 copayment
Barium enemas	\$0 copayment
Digital rectal exams	\$0 copayment
EKG following preventive services	\$0 copayment
Other Medicare-covered preventive services	\$0 copayment
<b>Emergency care</b>	0% or 20% coinsurance, up to \$120 each visit Coinsurance is waived if you are admitted to a hospital within 24 hours for the same condition.
<b>Urgently needed services</b>	0% or 20% coinsurance, up to \$65 each visit
<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% or 20% coinsurance for diagnostic services/labs/imaging  PCP or Specialist coinsurance also applies if service is provided during an office visit.  <i>Prior authorization is required for certain services provided by your doctor or other network provider. Please contact the plan for more information.</i>

<b>Health Partners Medicare Special</b>	
<b>Medical Benefits (Part C)</b>	
<b>Hearing services</b>	
Medicare-covered hearing exam	0% or 20% coinsurance for Medicare-covered services
Routine hearing exam	\$0 copayment for routine hearing exam (limited to 1 visit every year)
<b>Hearing aids</b>	\$1,500 toward hearing aids every year
<b>Dental services</b>	
Preventive dental services	You pay \$0 copay for 2 exams and cleanings per year, 1 set of X-rays per year and 1 fluoride treatment per year.
Comprehensive dental services	0% or 20% of the cost for Medicare-covered dental benefits  Comprehensive dental services coverage (up to a maximum of \$3,000 per year) includes: <ul style="list-style-type: none"> <li>• Non-routine services</li> <li>• Diagnostic services</li> <li>• Restorative services</li> <li>• Endodontics</li> <li>• Periodontics</li> <li>• Extractions</li> <li>• Prosthodontics</li> <li>• Other oral/maxillofacial surgery</li> <li>• Other services</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% or 20% coinsurance for Medicare-covered services  \$0 copayment for Medicare-covered eyewear
Routine eye exam	\$0 copayment for routine eye exam (limited to 1 visit every year)
Supplemental eyeglasses or contact lenses	\$0 copayment for supplemental eyewear (up to a \$200 limit toward eyeglasses or contact lenses every year)

	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Mental health services</b>	
Inpatient visit	<p>For each hospital admission/stay you pay:</p> <ul style="list-style-type: none"> <li>• \$1,408 deductible</li> <li>• \$0 copayment for days 1 -60</li> <li>• \$352 copayment per day for days 61-90</li> <li>• \$704 copayment each day for days 91 to 150 (lifetime reserve days).</li> </ul> <p>Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies).</p> <p>Our plans also cover 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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p><i>Prior authorization is required</i></p>
Outpatient group therapy visit	0% or 20% coinsurance
Outpatient individual therapy visit	0% or 20% coinsurance
<b>Skilled nursing facility</b>	<p>Days 1 to 20: \$0 copayment per day</p> <p>Days 21 to 100: \$170.50 copayment each day*</p> <p>Our plan covers up to 100 days in a skilled nursing facility during each benefit period.</p> <p><i>Prior authorization is required</i> during each benefit period.</p>
<b>Physical/occupational/speech &amp; language therapy</b>	<p>0% or 20% coinsurance</p> <p><i>Prior authorization is required</i></p>
<b>Ambulance services</b>	0% or 20% coinsurance
Ground Ambulance	
Air Ambulance	<i>Prior authorization is required for non-emergency ambulance transportation.</i>

	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<b>Transportation (routine)</b>	\$0 copayment Up to 85 one-way van or medical transport trips each year to plan-approved health-related locations.
<b>Medicare Part B prescription drugs</b> Chemotherapy drugs Other Part B drugs	0% or 20% coinsurance  <i>Prior authorization is required.</i>
<b>Podiatry services</b> Medicare-covered services include: <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> Routine foot care	0% or 20% coinsurance for Medicare-covered services  \$20 copayment for routine foot care (limited to one visit every three months)
<b>Durable medical equipment (DME) and related supplies</b>	0% or 20% coinsurance  <i>Prior authorization is required for DME costing more than \$500.</i>
<b>Prosthetics/orthotics</b>	0% or 20% coinsurance  <i>Prior authorization is required for prosthetics/orthotics costing more than \$500.</i>
<b>Diabetic supplies</b>	0% or 20% coinsurance for diabetic supplies from preferred manufacturers 20% coinsurance for diabetic supplies from non-preferred manufacturers
<b>Fitness program</b>	\$0 copayment for up to \$50 per month towards annual membership.  If using a SilverSneakers facility, there will be no out-of-pocket costs.

	<b>Health Partners Medicare Special</b>
<b>Medical Benefits (Part C)</b>	
<p><b>Telemedicine</b></p> <p>Members have 24/7/365 access to credentialed providers 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 or nurse practitioner 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 copayment
<p><b>Telemonitoring</b></p> <p>Home telemonitoring devices will be offered to Members who have congestive heart failure (CHF) or Diabetes. Members will be provided clinical support through an application which allows chat, phone calls and video chat.</p> <p>In addition, scales and blood pressure cuffs may be offered to members with CHF and hypertension. The purpose of the items is to enable these specific members to monitor their blood pressure and body weight, and report to their doctor according to the doctor's direction. A doctor must recommend that a member needs these items. Limitations may apply.</p>	<p>\$0 copayment for telemonitoring services</p> <p><i>Prior authorization is required.</i></p>
<b>Acupuncture services</b>	\$5 copayment (limited to 20 visits every year)
<b>Annual wellness exam</b>	Not covered
<b>Cardiac rehabilitation services</b>	0% or 20% coinsurance



## 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. Your Medicare cost-sharing responsibility is largely based on your category of Medicaid eligibility.

Medicare coverage must be used first. Medicaid may then cover payment of your cost-sharing for Medicare-covered services, depending on your Medicaid category.

**If your Medicaid category is Qualified Medicare Beneficiary Plus (QMB+), you will pay \$0 for those services covered by our plan that show “0% or 20% of the cost” in this Summary of Benefits.**

**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.

**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>Primary Care Provider</b>	No limits	0% or 20% of the cost for each Medicare-covered primary care doctor visit
<b>Physician Services and Medical and Surgical Services provided by a Dentist</b>	No limits	0% or 20% of the cost for each Medicare-covered specialist visit  0% or 20% of the cost for Medicare-covered dental benefits  \$0 copay for the following preventive dental benefits: <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 fluoride treatment every year</li> <li>• 1 set of dental X-rays every year</li> </ul> \$3,000 plan coverage limit for supplemental comprehensive dental benefits every year
<b>Certified Registered Nurse Practitioner</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit
<b>Federally Qualified Health Center/Rural Health Clinic</b>	No Limits except for Dental Care Services as described below	0% or 20% of the cost for each Medicare-covered visit  Also see Dental Care Services described below.
<b>Independent Clinic</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit

<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>Outpatient Hospital Clinic</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit
<b>Podiatrist Services</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit  \$20 copay for routine foot care visits (limited to one every three months)
<b>Chiropractor Services</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit  \$0 copay for routine visits (limited to 20 visits yearly)
<b>Optometrist Services</b>	2 visits (exams) yearly	0% or 20% of the cost for each Medicare-covered visit  \$0 copay 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  (Hospice care is covered by Original Medicare.)
<b>Radiology (including X-Rays, MRIs and CTs)</b>	No Limits	0% or 20% of the cost 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% or 20% of the cost for each Medicare-covered service</p> <p>\$0 copay for two oral exams and two cleanings yearly</p> <p>\$0 copay for one fluoride treatment yearly</p> <p>\$0 copay for one set of X-rays yearly</p> <p>\$3,000 allowance yearly for supplemental comprehensive dental services</p>
<b>Outpatient Hospital Short Procedure Unit (SPU)</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit
<b>Outpatient Ambulatory Surgical Center (ASC)</b>	No Limits	0% or 20% of the cost 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	0% or 20% of the cost for each Medicare-covered service  \$0 copay for routine transportation to plan approved locations (limited to 85 one-way trips yearly)
<b>Family Planning Clinic, Services and Supplies</b>	No Limits	Not covered
<b>Renal Dialysis</b>	Initial training for home dialysis is limited to 24 sessions per patient yearly.  Backup visits to the facility are limited to 75 visits yearly	0% or 20% of the cost for each Medicare-covered visit
<b>Emergency Room</b>	No Limits	0% or 20% of the cost for each Medicare-covered visit
<b>Ambulance (Emergency)</b>	No Limits	0% or 20% of the cost 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 \$0 or:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$1,408 deductible</li> <li>• Days 61–90: \$352 each day</li> <li>• \$704 copay 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>

**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 \$0 or:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$1,408 deductible</li> <li>• Days 61–90: \$352 each day</li> <li>• \$704 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 \$0 or:</p> <ul style="list-style-type: none"> <li>• Days 1–60: \$1,408 deductible</li> <li>• Days 61–90: \$352 each day</li> <li>• \$704 copay 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% or 20% of the cost 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% or 20% of the cost for each Medicare-covered individual therapy visit</p> <p>0% or 20% of the cost 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>Depending on your income, institutional status and level of Extra Help, 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), either: <ul style="list-style-type: none"> <li>○ \$0 copay or</li> <li>○ \$1.30 copay or</li> <li>○ \$3.60 copay or</li> <li>○ up to 25% of the cost</li> </ul> </li> <li>• For all other drugs, either: <ul style="list-style-type: none"> <li>○ \$0 copay or</li> <li>○ \$3.90 copay or</li> <li>○ \$8.95 copay or</li> <li>○ up to 25% of the cost</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><b>Note:</b> Specialty drugs aren't available for an extended-day supply.</p>
<b>Nutritional Supplements</b>	No Limits	Not covered

**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 each day</li> <li>• Days 21–100: \$0 or \$176 each day</li> </ul>
<b>Home Health Care (includes Nursing, aide and therapy services)</b>	Unlimited for first 28 days. Limited to 15 days every month thereafter.	\$0 copay 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% or 20% of the cost 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% or 20% of the cost for Medicare-covered prosthetic devices, related medical supplies, and therapeutic shoes and inserts</p> <p>0% or 20% of the cost 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 for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery</p> <p>Up to \$200 for one pair of eyeglasses or contact lenses yearly</p>
<b>Medical Supplies</b>	No limits	0% or 20% of the cost for Medicare-covered medical supplies

**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>Therapy (Physical, Occupational, Speech)</b>	Covered only when provided by a hospital, outpatient clinic or home health provider	0% or 20% of the cost for Medicare-covered physical therapy, occupational therapy and speech and language therapy visits
<b>Laboratory Services</b>	No limits	0% or 20% of the cost 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 Services</b>  <b>Community Transition 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.</p> <p>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.</p> <p>(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.)</p> <p>Community Transition Services are limited to a combined \$4,000 per participant, per lifetime, as preauthorized by the State Medicaid Agency program office.</p> <p>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.</p> <p>Under Specialized Medical Equipment and Supplies, non-covered items include:</p> <p>All prescription and over-the-counter medications, compounds and solutions (except wipes and barrier cream).</p> <p>Items covered under third party payer liability.</p>	<p>Home Delivered Meals covered up to four weeks for members with uncontrolled diabetes or congestive heart failure.</p> <p>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	\$5 copay for each visit, for up to 20 visits a year
<b>Dental</b>	See Dental Care Services in earlier Adult Benefit Package section for coverage details.	\$0 copay for two oral exams and two cleanings yearly \$0 copay for one fluoride treatment yearly \$0 copay for one set of X-rays yearly \$3,000 allowance yearly for supplemental comprehensive dental services
<b>Fitness</b>	Not covered	\$0 copay for SilverSneakers <sup>®</sup> fitness program membership
<b>Hearing</b>	Not covered	\$0 copay for one routine hearing exam yearly \$1,500 hearing aid allowance yearly
<b>Meals</b>	Not covered	\$0 copay for up to four weeks of home-delivered meals for members with uncontrolled diabetes or congestive heart failure
<b>Podiatry (Routine)</b>	No limits	\$20 copay for each visit (limited to one visit every three months)
<b>Over-the-Counter Items</b>	Not covered	\$300 quarterly allowance at participating pharmacies (unused amounts cannot be carried over)

**Summary of Medicaid-Covered Benefits  
Supplemental Benefits  
(not covered by Original Medicare)**

<b>Benefit Category</b>	<b>Medicaid</b>	<b>Health Partners Medicare Special (HMO SNP) In-Network</b>
<b>Transportation (Routine)</b>	Available through Medical Assistance Transportation Program	\$0 copay for 85 one-way trips to plan-approved locations yearly
<b>Vision Care</b>	Two exams covered yearly  Eyeglasses and contacts limited to individuals diagnosed with aphakia (up to two frames and four lenses or four contact lenses yearly)	\$0 copay for one routine exam yearly  Up to \$200 for one pair of eyeglasses or contact lenses yearly

## 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

- Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. 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.

### 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, 2021.
- Except in emergency or urgent situations, 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.





**Health Partners Medicare**

901 Market Street, Suite 500  
Philadelphia, PA 19107

**1-866-901-8000 (TTY 1-877-454-8477)**

**HPPMedicare.com**

**Health Partners** Plans



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