2021 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, 2021 - December 31, 2021.

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 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 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 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.

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: 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.

	Health Partners Medicare Special
Monthly plan premium	$0 Note: If your level of "Extra Help" changes, you may be responsible for a monthly premium up to $37.50. You also must continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.
Deductible	The Part B deductible is $0. 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 $203. There is a $0 deductible for prescription drugs while you receive full "Extra Help." If your level of "Extra Help" changes, you may be responsible for up to a $445 deductible.
Maximum out-of-pocket amount responsibility *(does not include prescription drugs)*	$3,450 annually The most you pay for copay, coinsurance and other costs for medical services for the year.

		Health Partners Medicare Special
Outpatient Prescription Drugs (Part D)		
	Standard retail cost-sharing (in-network and out-of-network) (up to a 30-day supply)	**Mail order cost-sharing** (up to a 90-day supply)
Deductible	$0 for all Part D prescription drugs if you receive full Extra Help; up to $445 if you do not.	
Cost-sharing for covered drugs	If you receive full Extra Help you pay: $0 or $1.30 or $3.70 for generic drugs $0 or $4.00 or $9.20 for all other drugs If you do not receive full Extra Help, you will pay no more than 25% coinsurance. Drugs noted as "non-extended day supply" in our plan Formulary are not available by mail order.	
Coverage Gap	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 $4,130, you will pay no more than 25% coinsurance for brand name and generic drugs (plus a portion of the dispensing fee for brand name drugs) during the coverage gap.	
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay $0 if you receive full Extra Help. If you do not receive full Extra Help you pay the greater of: • 5% coinsurance, or • $3.70 copay for generics (including brand drugs treated as generic) and a $9.20 copay for all other drugs.	
Long-term care pharmacy and out-of-network pharmacy coverage	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 *Evidence of Coverage* at www.HPPMedicare.com or call us at 1-866-901-8000 (TTY 711). You can call 24 hours a day, seven days a week.	

	Health Partners Medicare Special
Medical Benefits (Part C)	
Inpatient hospital coverage	For each hospital admission/stay you pay: • $0 deductible; • $0 copay each day for days 1-60; • $0 copay each day for days 61 to 90; • $0 copay each day for days 91 and beyond (lifetime reserve days). 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. ***All elective inpatient admissions require prior authorization. All other admissions will be reviewed for medical necessity and authorization.***
Outpatient hospital coverage	
Outpatient hospital visits	0% coinsurance
Outpatient hospital observation services	0% coinsurance
Services provided at an ambulatory surgical center	0% coinsurance ***Prior Authorization is required for outpatient hospital visits and ambulatory surgical center visits.***
Doctor visits	
Primary Care Providers	0% coinsurance
Specialists	0% coinsurance
Medicare-covered preventive care	
Annual wellness exam	$0 copay
Barium enemas	$0 copay
Diabetes self-management training	$0 copay

	Health Partners Medicare Special
Medical Benefits (Part C)	
Medicare-covered preventive care (cont)	
Digital rectal exams	$0 copay
EKG following preventive services	$0 copay
Glaucoma screening	$0 copay
Other Medicare-covered preventive services	$0 copay
Emergency care	0% coinsurance
Urgent care	0% coinsurance
Diagnostic services/labs/imaging	
• Diagnostic tests and procedures • Lab services • Advanced radiology services (such as MRI, PET, CT and nuclear medicine) • Outpatient diagnostic imaging tests (such as X-rays, ultrasound and mammography) • Therapeutic radiology (such as radiation treatment for cancer)	0% coinsurance for diagnostic services/labs/imaging ***Prior authorization is required (except for lab services and X-rays).***
Hearing services	
Medicare-covered hearing exam	0% coinsurance for Medicare-covered services
Routine hearing exam	$0 copay for routine hearing exam (limited to 1 visit every year)

	Health Partners Medicare Special
Medical Benefits (Part C)	
Hearing aids	$1,500 toward hearing aids every year
Dental services	
Preventive dental services	You pay $0 copay for 2 exams and cleanings per year. X-rays covered (limits apply).
Medicare-covered dental services Supplemental comprehensive dental services	0% of the cost for Medicare-covered dental services Supplemental comprehensive dental services coverage (up to a maximum of $3,500 per year) includes: • Diagnostic services • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral/maxillofacial surgery ***Prior authorization is required.***
Vision care	
Medicare-covered services include: • Exam to diagnose and treat diseases and conditions of the eye	0% coinsurance for Medicare-covered services
• Eyewear after cataract surgery	$0 copay for Medicare-covered eyewear
Routine eye exam	$0 copay for routine eye exam (limited to 1 visit every year)
Supplemental eyeglasses (frame and lenses), frame only, lenses only, or contact lenses	$0 copay for your choice of one of the following yearly: - one pair of eyeglasses (lenses and up to $150 for frame) - one pair of eyeglass lenses - up to $150 for one eyeglass frame - up to $200 for contact lenses.

	Health Partners Medicare Special
Medical Benefits (Part C)	
Mental health services	
Inpatient mental health coverage	For each hospital admission/stay you pay: • $0 deductible • $0 copay for days 1-60 • $0 copay per day for days 61-90 • $0 copay each day for days 91 and beyond (lifetime reserve days). Our plan covers up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). Our plan also covers 60 "lifetime reserve days." If your hospital stay is longer than 90 days, you can use these extra days. ***Prior Authorization is required.***
Outpatient group therapy visit Outpatient individual therapy visit Psychiatric services	0% coinsurance 0% coinsurance 0% coinsurance ***Prior authorization may be required for services other than routine outpatient therapy and medication management.***
Partial hospitalization	0% coinsurance per day ***Prior authorization is required.***
Skilled nursing facility	Days 1 to 20: $0 copay per day Days 21 to 100: $0 copay each day 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.) ***Prior Authorization is required during each benefit period.***

	Health Partners Medicare Special
Medical Benefits (Part C)	
Physical/occupational/speech & language therapy	0% coinsurance ***Prior Authorization is required.***
Ambulance services Ground Ambulance Air Ambulance	0% coinsurance ***Prior authorization is required for non-emergency ground or air ambulance trips.***
Transportation (routine) 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 may apply. See Evidence of Coverage for full details and restrictions related to benefit.	$0 copay for unlimited one-way trips each year to plan-approved locations.
Medicare Part B prescription drugs Chemotherapy drugs Other Part B drugs	0% coinsurance **Note:** Step therapy may apply for other Part B drugs. ***Prior Authorization is required.***
Acupuncture services Medicare-covered acupuncture for chronic low back pain Supplemental acupuncture services	 $0 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 for each supplemental acupuncture visit, limited to 20 visits each year
Cardiac rehabilitation services	0% coinsurance
Chiropractic services Medicare-covered services include: Manual manipulation of the spine to correct subluxation	0% coinsurance ***Prior Authorization is required.***

	Health Partners Medicare Special
Medical Benefits (Part C)	
Diabetic supplies Members will be responsible for 20% coinsurance for non-preferred diabetic monitoring supplies if they do not provide their Medicaid or CHC card at the pharmacy.	0% coinsurance for diabetic monitoring supplies from preferred manufacturers 0% coinsurance for diabetic monitoring supplies from non-preferred manufacturers 0% for all other Part B diabetic supplies ***Prior authorization is required for non-preferred diabetic monitoring supplies.***
Durable medical equipment (DME) and related supplies	0% coinsurance ***Prior authorization is required for certain DME and all DME rentals***
Fitness program	$0 copay for SilverSneakers® membership or membership to the Salvation Army Kroc Center of Philadelphia.
Home health care	0% coinsurance ***Prior Authorization is required.***
Meal benefit 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 for up to 84 meals in 28 days per year. Please contact the plan for more details. ***Prior Authorization is required.***
Opioid treatment services	0% coinsurance for each opioid treatment service
Over-the-counter (OTC) items The benefit period corresponds to the quarters of the calendar year: 1st quarter: Jan - Mar 2nd quarter: Apr - Jun 3rd quarter: Jul - Sept 4th quarter: Oct - Dec	$300 every calendar quarter toward eligible OTC items. Unused allowances carry over until the end of the plan year. **Note:** Unused amounts do not carry over into the following year.

	Health Partners Medicare Special
Medical Benefits (Part C)	
Podiatry services Medicare-covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Foot care for members with certain medical conditions affecting the lower limbs. Routine foot care	0% coinsurance for Medicare-covered services $20 copay for routine foot care (limited to one visit every three months)
Prosthetics/orthotics	0% coinsurance ***Prior Authorization is required.***
Pulmonary rehabilitation services	0% coinsurance
Telehealth (by a PCP or specialist) You have the option of receiving physician services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth.	0% coinsurance for these telehealth services: Primary Care Provider services Physician specialist services Mental Health Specialty individual sessions Psychiatric individual sessions ***Prior authorization is required (out-of-network only).***
Telemedicine 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 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.	$0 copay

	Health Partners Medicare Special
Medical Benefits (Part C)	
Telemonitoring An in-home telemonitoring program is covered for members who have congestive heart failure (CHF) or uncontrolled diabetes. Members will be provided clinical support while on the program through an application which allows chat, phone calls and video chat. In addition, blood pressure cuffs will be offered to members with uncontrolled hypertension. The purpose for this item is to enable these specific members to monitor their blood pressure and report to their doctor according to the doctor's direction. A doctor must recommend that a member needs these items. Limitations may apply.	$0 copay for telemonitoring services ***Prior authorization is required.***
Worldwide emergency/urgent coverage	$0 copay up to $5,000 maximum per year

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.

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Primary Care Provider	No limits	0% of the cost for each Medicare-covered primary care doctor visit
Physician Services and Medical and Surgical Services provided by a Dentist	No limits	0% of the cost for each Medicare-covered specialist visit 0% of the cost for Medicare-covered dental benefits $0 copay for the following preventive dental benefits: • up to 2 oral exams every year • up to 2 cleanings every year • 1 set of dental X-rays every year $3,500 plan coverage limit for supplemental comprehensive dental benefits every year
Certified Registered Nurse Practitioner	No Limits	0% of the cost for each Medicare-covered visit
Federally Qualified Health Center/Rural Health Clinic	No Limits except for Dental Care Services as described below	0% of the cost for each Medicare-covered visit Also see Dental Care Services described below.
Independent Clinic	No Limits	0% of the cost for each Medicare-covered visit

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Outpatient Hospital Clinic	No Limits	0% of the cost for each Medicare-covered visit
Podiatrist Services	No Limits	0% of the cost for each Medicare-covered visit $20 copay for routine foot care visits (limited to one every three months)
Chiropractor Services	No Limits	0% of the cost for each Medicare-covered visit
Optometrist Services	2 visits (exams) yearly	0% of the cost for each Medicare-covered visit $0 copay for routine exam (limited to one yearly)
Hospice Care	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.)
Radiology (including X-Rays, MRIs and CTs)	No Limits	0% of the cost for each Medicare-covered service

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

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Non-Emergency Medical Transport	Only to and from Medicaid-covered services	0% of the cost for each Medicare-covered service $0 copay for routine transportation to plan approved locations (unlimited one-way trips each year to plan-approved locations.)
Family Planning Clinic, Services and Supplies	No Limits	Not covered
Renal Dialysis	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% of the cost for each Medicare-covered visit
Emergency Room	No Limits	0% of the cost for each Medicare-covered visit
Ambulance (Emergency)	No Limits	0% of the cost for each Medicare-covered service

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Inpatient Acute Hospital or Inpatient Rehab Hospital	No Limits	Plan covers up to 90 days for each inpatient stay. In addition, there are 60 lifetime reserve days. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 each day • $0 copay each day Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Inpatient Psychiatric Hospital	No Limits	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. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 each day • $0 each day for up to 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Inpatient Drug & Alcohol	No Limits	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. The amounts for each inpatient stay are: • Days 1–60: $0 deductible • Days 61–90: $0 each day • $0 copay each day for 60 lifetime reserve days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.
Maternity (Physician, Certified Nurse Midwives, Birth Centers)	No Limits	0% of the cost for each Medicare- covered physician and certified nurse midwife service; birth centers not covered
Mental Health and Substance Abuse (Behavioral Health) including: **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.**	No limits except: Targeted case management for behavioral health only is limited to individual with serious mental illness. Targeted case management for other than behavioral health is limited to individuals identified in the target group.	0% of the cost for each Medicare- covered individual therapy visit 0% of the cost for each Medicare-covered group therapy visit Also see Prescription Drugs coverage below.

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Prescription Drugs	No Limits	Depending on your income, institutional status and level of Extra Help, you pay the following during the Initial Coverage Period: • For generic drugs (including brand drugs treated as generic), either: ○ $0 copay or ○ $1.30 copay or ○ $3.70 copay or ○ up to 25% of the cost • For all other drugs, either: ○ $0 copay or ○ $4.00 copay or ○ $9.20 copay or ○ up to 25% of the cost • You can get drugs the following way(s): ○ 1-month (30-day) supply ○ 2-month (60-day) supply ○ 3-month (90-day) supply Note: Drugs noted in our plan formulary as “non-extended day supply” are not available as more than a 30-day supply.
Nutritional Supplements	No Limits	Not covered

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Skilled Nursing Facility	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: • Days 1–20: $0 each day • Days 21–100: $0 each day
Home Health Care (includes Nursing, aide and therapy services)	Unlimited for first 28 days. Limited to 15 days every month thereafter.	$0 copay for Medicare-covered home health visits
Intermediate Care Facility (ICF/IID and ICF/ORC)	No limits but requires an institutional level of care.	Not covered
Durable Medical Equipment	No limits	0% of the cost for Medicare-covered durable medical equipment

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Prosthetics and Orthotics	Orthopedic shoes and hearing aids are not covered. 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. Coverage of modifications to orthopedic shoes and molded shoes is limited to only modifications necessary for the application of a brace or splint. Coverage for low vision aids and eye prostheses is limited to one every two years. Coverage for an eye ocular is limited to one yearly.	$1,500 hearing aid allowance yearly 0% of the cost for Medicare-covered prosthetic devices, related medical supplies, and therapeutic shoes and inserts 0% of the cost for other Medicare-covered items Low vision aids not covered
Eyeglasses and Contact Lenses	Eyeglasses limited to 4 lenses and 2 frames yearly for individuals diagnosed with aphakia. Deluxe frames not included Contact lenses limited to 4 lenses yearly for individuals diagnosed with aphakia.	$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery $0 copay for supplemental eyewear (your choice of one of the following yearly): - one pair of eyeglasses (lenses and up to $150 for frame) - one pair of eyeglass lenses - up to $150 for one eyeglass frame - up to $200 for contact lenses.

Summary of Medicaid-Covered Benefits Adult Benefit Package		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Medical Supplies	No limits	0% of the cost for Medicare-covered medical supplies
Therapy (Physical, Occupational, Speech)	Covered only when provided by a hospital, outpatient clinic or home health provider	0% of the cost for Medicare-covered physical therapy, occupational therapy and speech and language therapy visits
Laboratory Services	No limits	0% of the cost for Medicare-covered lab services
Tobacco Cessation	70 15-minute units covered yearly	Two counseling quit attempts covered yearly

Summary of Medicaid-Covered Benefits Home and Community-Based Services		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Adult Daily Living Services **Assistive Technology** **Behavior Therapy** **Benefits Counseling** **Career Assessment** **Cognitive Rehabilitation Therapy** **Community Integration** **Community Transition Services** **Counseling** **Employment Skills Development** **Home Adaptations** **Home Delivered Meals** **Home Health Aide** **Home Health – Nursing** **Home Health – Occupational Therapy** **Home Health – Physical Therapy** **Home Health – Speech and Language Therapy** **Job Coaching** **Job Finding** **Non-Medical Transportation** **Nutritional Counseling** **Participant-Directed Community Supports** **Participant-Directed Goods and Services** **Personal Assistance Services** **Personal Emergency Response System** **Pest Eradication** **Residential Habilitation** **Respite** **Service Coordination** **Specialized Medical Equipment and Supplies**	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.	Home Delivered Meals covered up to 84 meals and 28 weeks each year for members with uncontrolled diabetes or congestive heart failure. See Adult Benefit Package section above for coverage information about these benefits: • Home Health Care • Non-Emergency Medical Transport • Durable Medical Equipment • Medical Supplies Other services listed are not covered.

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

Summary of Medicaid-Covered Benefits Supplemental Benefits (not covered by Original Medicare)		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Acupuncture	Not covered	$0 copay for each supplemental acupuncture visit, limited to 20 visits each year.
Dental	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 X-rays (limits apply) $3,500 allowance yearly for supplemental comprehensive dental services
Fitness	Not covered	$0 copay for SilverSneakers© fitness program membership
Hearing	Not covered	$0 copay for one routine hearing exam yearly $1,500 hearing aid allowance yearly
Meals	Not covered	$0 copay for up to 84 home-delivered meals over 28 weeks each year for members with uncontrolled diabetes or congestive heart failure
Podiatry (Routine)	No limits	$20 copay for each visit (limited to one visit every three months)
Over-the-Counter Items	Not covered	$300 quarterly allowance (unused amounts can be carried over throughout the plan year).
Transportation (Routine)	Available through Medical Assistance Transportation Program	$0 cost share for unlimited one-way trips each year to plan-approved locations.

Summary of Medicaid-Covered Benefits Supplemental Benefits (not covered by Original Medicare)		
Benefit Category	**Medicaid**	**Health Partners Medicare Special (HMO SNP) In-Network**
Vision Care	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 $0 copay for supplemental eyewear (your choice of one of the following yearly): • one pair of eyeglasses (lenses and up to $150 for frame) • one pair of eyeglass lenses • up to $150 for one eyeglass frame • up to $200 for contact lenses.

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 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, 2022.
- ☐ 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.