Chapter 5
Health Partners Medicare Summary of Benefits

Purpose: This chapter provides an overview of the benefits available to Health Partners Medicare members

Topics: Important topics from this chapter include:

- Summary of Medicare benefits
  - Health Partners Medicare **Prime** (HMO)
  - Health Partners Medicare **Special** (HMO SNP)
- Non-Covered Services

Overview

This chapter provides an overview of the 2019 benefits that Health Partners Medicare members are entitled to and guidelines for appropriately utilizing authorizations.

Health Partners Medicare Background

In 2014, Health Partners Plans (HPP) launched Health Partners Medicare (HP Medicare) in Philadelphia County. Since then, the HP Medicare service area has expanded to a total of seven counties in Southeast Pennsylvania.

Regulatory Compliance

As a Medicare Advantage plan in a contract with the Centers for Medicare & Medicaid Services (CMS), HP Medicare complies with all applicable CMS regulations. Not only does HP Medicare have a comprehensive Medicare Compliance program, led by a Medicare Compliance officer, every operational area at HPP is responsible for the compliance of its functions. Should you have any questions about our Medicare Compliance program, please contact our Provider Services Helpline at **1-888-991-9023**.

Among the requirements with which HP Medicare complies, are:

- We provide CMS with specific information about our plans that CMS makes available to current and potential beneficiaries to enable them to make informed decisions about their Medicare options. This includes: plan benefits; cost sharing; service area; rate of disenrollment; enrollee satisfaction; health outcomes; the plan's compliance record; member appeals; and formal actions of other regulatory bodies.
- In the HPP contract with CMS, we formally agreed to comply with all applicable regulations and instructions from CMS. Among the topics covered: enrollment and disenrollment; non-discrimination; provision of basic benefits; and access to benefits.
- The manner and form of communicating information to beneficiaries.
- Formal reporting on the financial status of HPP.

Summary of Benefits

Health Partners Medicare

The benefits offered by Medicare Advantage plans can change annually, and Health Partners Medicare has been no exception. Each year Health Partners Medicare submits its proposed plans for the following year to the Centers for Medicare & Medicaid Services (CMS) for approval. Benefits for the subsequent year are usually approved by CMS by early September; and benefits stay the same for a calendar year. It is rare that CMS requires Medicare Advantage plans to make benefit changes in the middle of a calendar year.

The benefits tables in this chapter reflect Health Partners Medicare plans for the calendar year 2019, summarize benefits and services, and provide key information about cost sharing, benefit limits and prior authorization.

It is especially important for HPP providers to be aware of the plans, the benefits available to members, and cost-sharing that providers should expect from members.

Please note: Providers are prohibited from billing our dual eligible members for any Medicare cost-sharing for Part A & B covered services. Additionally, providers should bill any Medicare cost-sharing to the member's assigned Community HealthChoices (CHC) plan.

Please note that most Health Partners Medicare plans require PCP referrals for plan specialists.

See the PCP Referrals: Medicare section on page 11.6 of the Provider Billing & Reimbursement chapter for more information.

Billing Full Dual Eligible Members for Medicare Cost-Sharing

Medicare cost-sharing includes copayments, coinsurance and deductibles. The cost-sharing responsibility for dual eligible members (have both Medicare and Medicaid coverage) is based on their category of Medicaid eligibility. Medicaid will pay the Medicare Part A and B service cost-sharing for any Full Dual Eligible members, so long as the benefit is covered by both Medicare & Medicaid. Medicaid will cover Medicare cost sharing up to the difference between the Medicare paid amount and the Medicaid rate for the service. If the Medicaid rate is lower than the Medicare rate, Medicaid may not remit payment and the provider will be considered paid in full. Specific to QMB and QMB Plus members, under federal law, members enrolled in the QMB program,

including QMB Plus, are exempt from liability for Medicare deductibles, co-insurance, or co-payments. As a contracted provider, you are prohibited from billing QMB and QMB Plus members for Medicare cost-sharing, even if the service isn't covered by Medicaid.

Coverage of the Medicaid benefits are now being administered by Medicaid Managed Care Organizations referred to as Community HealthChoices Plans (CHC). Providers should bill any remaining Medicare cost-sharing to the member's CHC for remittance of payment and should not seek additional payments directly from Pennsylvania's Department of Human Services (DHS). As the member's Medicare provider, you are not obligated to participate in the CHC's network in order to submit claims.

Separate benefit tables are provided on the following pages for *each* of our Medicare plans:

- Health Partners Medicare Prime (HMO)
- Health Partners Medicare Special (HMO SNP) (Enrollment requires both Medicare and Medicaid eligibility)

Prior authorization is **ALWAYS REQUIRED** for out-of-network services, except emergency/urgent care, family planning, maternity care, and dialysis.

Table 5.1: Health Partners Medicare Prime (HMO) 2019 Benefits		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
Acupuncture Services	▪ $5 copayment limited to 20 visits every year.	▪ N/A
Ambulance Services	▪ $210 copayment for Ground Ambulance ▪ 20% coinsurance for Air Ambulance	▪ Yes (For non-emergent ambulance)
Audiology Services	▪ $0 copayment for one routine hearing exam every year; ▪ $50 copayment for Medicare-covered hearing exams. ▪ Hearing Aids not covered	▪ No
Pulmonary Rehabilitations Services	▪ $30 copayment for Medicare-covered pulmonary rehab services.	▪ No
Chiropractic Services	▪ $20 copayment for Medicare covered services: Only manual manipulation of the spine to correct subluxation.	▪ Yes Contact eviCore)
Dental Services- **Preventative** **Comprehensive**	▪ $0 copayment for 2 oral exams/cleanings per year; one set X-rays per year; one fluoride treatment per year ▪ $500 allowance per year for supplemental comprehensive dental benefits ($50 deductible)	▪ Yes (Contact Avesis)
Diabetes Programs and Supplies	▪ $0 copayment for preferred test strips and monitors; ▪ 20% for other diabetes supplies; ▪ $0 copayment for diabetes self-management training	▪ No
Diagnostic services/labs/imaging	▪ $0 copayment for diagnostic tests/procedures ▪ $30 copayment for outpatient diagnostic imaging tests (such as X-rays, ultrasound and mammography) ▪ $250 copayment for advanced radiology services (MRI, MRA, PET, CT and nuclear medicine)	▪ Yes (Contact eviCore for): – Advanced Radiology, – Nuclear Cardiology, – TTE/TEE, – Sleep studies – Prior authorization is required for certain services provided by your

Table 5.1: Health Partners Medicare Prime (HMO) 2019 Benefits		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	▪ 20% coinsurance plus PCP or Specialist copayment also applies if service is provided during an office visit for Therapeutic Radiology (such as radiation treatment for cancer)	doctor or other network provider
Doctor Visits	▪ $0 copayment for each primary care visit; ▪ $50 copayment for each specialist visit. (Referral is required)	▪ No
Durable Medical Equipment (DME) and related supplies	▪ 20% coinsurance	▪ Yes (For rentals DME items over $500)
Emergency Care	▪ $90 copayment per covered visit; ▪ Copayment is waived if admitted to the hospital within 24 hours for the same condition	▪ No (If member reasonably believes emergency care is needed)
Fitness Program (Gym) Membership	▪ Plan pays for an annual membership at participating fitness centers or a Home Fitness Kit.	▪ No
Home Infusions	▪ $0 copayment per visit	▪ Yes
Home Health Care	▪ $0 copayment per visit	▪ Yes
Inpatient Hospital Coverage	▪ Hospital stays capped at 90 days. Cost sharing begins on day 1 of every inpatient stay. ▪ For plans 002 & 005: – $300 copayment per day for days 1-6 – $0 copayment days 7-90 – $0 copay days 91-150 (lifetime reserve days) ▪ For plan 010 (Lancaster, Lehigh, Northampton counties): – $300 copayment per day for days 1-6	▪ Yes (All elective inpatient admissions require prior authorization. All other admissions will be reviewed for medical necessity and authorization)

Table 5.1: Health Partners Medicare Prime (HMO) 2019 Benefits		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	– $0 copayment for days 7-90 – $0 copay for days 91-150 (lifetime reserve days) ▪ HPP offers 60 'lifetime reserve days'. These are "extra" days that the plan will cover. If the members' hospital stay is longer than 90 days, lifetime reserve days can be applied. Once these extra 60 days have exhausted, inpatient hospital coverage will be limited to 90 days.	
Renal Dialysis Services	▪ 20% ▪ No copay for diabetic education	▪ No
Laboratory Services	▪ $0 copayment for lab services/tests.	▪ No
Mental Health Care (Inpatient)	▪ $225 copay per day for days 1-7; ▪ $0 copay per day for days 8-90 ▪ $0 copay per day for days 91-150 ▪ HPP offers 60 'lifetime reserve days'. These are "extra" days that the plan will cover. If the members' hospital stay is longer than 90 days, lifetime reserve days can be applied. Once these extra 60 days have exhausted, inpatient hospital coverage will be limited to 90 days.	▪ Yes (Contact Magellan Behavioral Health)
Mental Health Care (Outpatient)	▪ $40 copay per individual therapy and group therapy visits	▪ Yes (Contact Magellan Behavioral Health)
Outpatient Hospital Services	▪ $200 copay for each ambulatory surgical center visit; ▪ $300 copay for each outpatient hospital facility visit ▪ $300 copay for Observation	▪ Yes (Contact eviCore for): – Joint and back surgery; – Pain management; – Cardiac rhythm implantable devices; – Automatic implantable cardioverter defibrillators; – Diagnostic cardiac

Table 5.1: Health Partners Medicare Prime (HMO) 2019 Benefits		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
		catheterizations – Chemotherapy (medical oncology) ▪ Yes (Contact HPP for): – Vascular Surgery – Hyperbaric oxygen therapy
Physical/Occupational/Speech Therapy Services (Outpatient)	▪ $40 copay per visit	▪ Yes (Contact eviCore)
Podiatry Services	▪ $50 copay for Medicare-covered foot care 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 (Referral Required)	▪ No
Prescription Drugs (Outpatient)	▪ $7 copay for Tier 1, Preferred Generic for up to a 30-day supply, ▪ $14 copay for Tier 1, 31 to 90-day supply. ▪ $20 copay for Tier 2, Generic for up to a 30-day supply, and ▪ $40 copay for Tier 2, 31-90 day supply. ▪ $350 deductible for Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug) and Tier 5 (Specialty). After deductible is met: – $47 copay for Tier 3 Preferred Brand for up to a 30-day supply and – $94 copay for a 31 to 90-day supply ▪ 25% coinsurance for Tier 4 Non-Preferred Drug;	▪ Required for certain drugs (See Formulary)

Table 5.1: Health Partners Medicare Prime (HMO) 2019 Benefits		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	▪ 26% coinsurance for Tier 5, Specialty medications; a long-term supply is not covered for drugs in Tier 5 ▪ Once the total yearly drug costs reach $3,820 the member enters the coverage gap phase where the coinsurance is no more than 25% for brand drugs and 37% for generic drugs. ▪ Once the member reaches the catastrophic phase with a total out of pocket expense of $5,100, the member pays the greater of 5% coinsurance or $3.40 copay for generic and $8.50 copay for all other drugs.	
Preventive Care	▪ $0 copay per visit for Medicare Covered Services	▪ No
Prosthetic Devices	▪ 20%	▪ Yes Over $500
Skilled Nursing Facility (SNF)	▪ Up to 100 days each benefit period; ▪ Days 1-20: $0 copay per day; ▪ Days 21-100: $172 copay per day	▪ Yes (No prior hospital stay required)
Substance Abuse Treatment (Outpatient)	▪ $50 copay per visit	▪ Yes (Contact Magellan Behavioral Health)
Transportation (Routine)	▪ Not covered	▪ N/A
Urgently Needed Care	▪ $65 copay per visit	▪ No
Vision Services	▪ $0 copay for one routine eye exam every year; ▪ $0 copay for eyewear after cataract surgery; ▪ $50 copay for exam to diagnose and treat diseases and conditions of the eye; ▪ $260 limit toward eyeglasses or contact lenses every 2 years	▪ No

** Medicare cost-sharing includes copayments, coinsurance and deductibles. Health Partners Medicare Special member's cost-sharing responsibility is based on their category of Medicaid eligibility. Medicaid will pay the Medicare Part A and B service cost-sharing for any Full Dual Eligible members, so long as the benefit is covered by both Medicare & Medicaid. Medicaid will cover Medicare cost sharing up to the difference between the Medicare paid amount and the Medicaid rate for the service. If the Medicaid rate is lower than the Medicare rate, Medicaid may not remit payment and the provider will be considered paid in full.*

Coverage of the Medicaid benefits are now being administered by Medicaid Managed Care Organizations referred to as Community HealthChoices plans (CHC). Providers should bill any remaining Medicare cost-sharing to the member's CHC for remittance of payment.

As the member's Medicare provider, you are not obligated to participate in the CHC's network in order to submit claims.

Please note, Federal law prohibits the billing of any Medicare Part A & B cost-sharing if a member's Medicaid category is Qualified Medicare Beneficiary Plus (QMB Plus); therefore, you are never to bill a QMB Plus member for Medicare Part A & B cost-sharing, even if the service is not covered by Medicaid.

Reminder Related to Billing Full Dual Eligible Members for Medicare Cost-Sharing

Health Partners Medicare Special Plan is a Full Benefit Dual Eligible Special Needs Plan. Medicaid will pay the Medicare Part A and B service cost-sharing for any Full Dual Eligible members, so long as the benefit is covered by both Medicare & Medicaid. Medicaid will cover Medicare cost sharing up to the difference between the Medicare paid amount and the Medicaid rate for the service. If the Medicaid rate is lower than the Medicare rate, Medicaid may not remit payment and the provider will be considered paid in full.

- Coverage of the Medicaid benefits are now being administered by Medicaid Managed Care Organizations referred to as Community HealthChoices plans (CHC). Providers should bill any remaining Medicare cost-sharing to the member's CHC for remittance of payment.
- As the member's Medicare provider, you are not obligated to participate in the CHC's network in order to submit claims.
- Please note, Federal law prohibits the billing of any Medicare Part A & B cost-sharing if a member's Medicaid category is Qualified Medicare Beneficiary Plus (QMB Plus); therefore, you are never to bill a QMB Plus member for Medicare Part A & B cost-sharing, even if the service is not covered by Medicaid.

Table 5.2: Health Partners Medicare Special (HMO SNP) 2019 Benefits Cost sharing in this plan depends on the member's Medicaid eligibility level.		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
Acupuncture	▪ $5 copay per visit up to 20 visits per year	▪ No
Ambulance Services	▪ $0 or 20% coinsurance for Ground Ambulance ▪ 0%-20% coinsurance for Air Ambulance	▪ Yes (For non-emergent ambulance)
Audiology Services	▪ 0% or 20% for Medicare-covered services; ▪ $0 copay for one routine hearing exam per year; ▪ $1,000 hearing aid allowance every 3 years	▪ No
Pulmonary Rehabilitation Services	▪ 0% or 20% coinsurance	▪ No
Chiropractic Services	▪ 0% or 20% for each Medicare-covered services include: Manual Manipulation of the spine to correct subluxation ▪ $0 copay for up to 20 routine visits every year	▪ Yes (Contact eviCore)
Dental Services	▪ 0% or 20% for Medicare-covered dental services; ▪ $0 copay for 2 dental exams/cleanings and one fluoride treatment and one set of dental X-rays per year; ▪ Additional supplemental coverage limited to $1,000 every year.	▪ Yes (Contact Avesis)
Diabetes Programs and Supplies	▪ 0% or 20% ▪ 0% coinsurance will apply to diabetes monitoring supplies from preferred manufacturers. 20% coinsurance will apply to diabetes monitoring supplies from non-preferred	▪ No ▪ Prior Authorization is required for supplies from non-preferred manufacturers.

Table 5.2: Health Partners Medicare Special (HMO SNP) 2019 Benefits Cost sharing in this plan depends on the member's Medicaid eligibility level.		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	manufacturers.	
Diagnostic Radiology	▪ 0% or 20% coinsurance for outpatient diagnostic imaging tests (such as X-Ray , ultrasound, and mammography) ▪ 0% to 20% for advanced radiology services (MRI, MRA, PET, CT and nuclear medicine)	▪ Yes (Contact eviCore for): – Advanced Radiology; – Nuclear Cardiology; – TTE/TEE; – Sleep studies
Doctor Office Visits	▪ 0% or 20% coinsurance for each primary care visit and specialist visit. (Referral is required)	▪ No
Durable Medical Equipment (DME) and related supplies	▪ 0% or 20% coinsurance	▪ Yes on items costing more than $500
Emergency Care	▪ 0% or 20% coinsurance up to $120 for each visit; ▪ Coinsurance is waived if admitted to the hospital within 24 hours for the same condition	▪ No (If a member reasonably believes emergency care is needed)
Fitness (Gym) Membership	▪ Plan pays for an annual membership at participating fitness centers or a Home Fitness Kit.	▪ No
Home Infusions	▪ $0 copay per visit	▪ Yes
Home Health Nursing Care, Home Social Workers, Aids and Home Therapists	▪ $0 copay per visit	▪ Yes
Hospital Care (Inpatient)	▪ Hospital stays capped at 90 days. Cost sharing begins on day 1 of every inpatient stay. – Days 1-60: $0 copay, or $1,364 deductible; – Days 61-90: $341 copay per day; – Days 91-150: $682 copay per lifetime reserve day	▪ Yes-All elective inpatient admissions require prior authorization. ▪ All other admissions will be reviewed for medical necessity and authorization.

Table 5.2: Health Partners Medicare Special (HMO SNP) 2019 Benefits Cost sharing in this plan depends on the member's Medicaid eligibility level.		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	▪ HPP offers 60 'lifetime reserve days'	
Renal Dialysis Services	▪ 0% or 20% coinsurance ▪ No copay for diabetic education	▪ No
Laboratory Services	▪ 0% or 20% coinsurance	▪ No
Meal Benefit	▪ $0 copayment covered up to four weeks, once per calendar year, for members with uncontrolled diabetes or congestive heart failure when ordered by physician or non-physician practitioner (referral is required)	▪ Yes
Medicare Part B prescription drugs	▪ Chemotherapy drugs up to 20% coinsurance ▪ Other Part B drugs up to 20% coinsurance	▪ Yes and/or Step Therapy
Mental Health Care (Inpatient)	▪ Days 1-60 $0 copay or $1,340 deductible; ▪ Days 61-90: $341 copay per day; ▪ Days 91-150: $682 copay per lifetime reserve day	▪ Yes (Contact Magellan Behavioral Health)
Mental Health Care (Outpatient)	▪ 0% or 20% coinsurance for outpatient group therapy and outpatient individual therapy visits	▪ Yes (Contact Magellan Behavioral Health)
Outpatient Hospital Services	▪ 0% or 20% coinsurance for each hospital visit, ambulatory surgical center visit and outpatient hospital observation facility	▪ Yes (Contact eviCore for): – Joint and back surgery; – Pain management; – Cardiac rhythm implantable devices; – Automatic implantable cardioverter defibrillators; – Diagnostic cardiac

Table 5.2: Health Partners Medicare Special (HMO SNP) 2019 Benefits Cost sharing in this plan depends on the member's Medicaid eligibility level.		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
		catheterizations – Chemotherapy (medical oncology) ▪ Yes (Contact HPP for): – Vascular Surgery; – Hyperbaric Oxygen Therapy
OTC Items	▪ $50 per month	▪ No.
Physical/Occupational/Speech Therapy Services (Outpatient)	▪ 0% or 20% coinsurance	▪ Yes (Contact eviCore)
Podiatry Services	▪ 0% or 20% coinsurance for each Medicare-covered services including 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; ▪ $20 copay for one routine care visit every three months	▪ No
Prescription Drugs (Outpatient)	▪ $0 annual deductible for dual eligible members; For members with Full Extra Help the member pays $0 copay or $1.25 copay or $3.40 for generic drugs (in network) (up to a 30-day supply) ▪ Up to a 90 day supply for members with Full Extra Help member pays $0 or $1.25 or $3.40 for generic drugs ▪ For all other drugs, $0 copay or $3.80 or $8.50 ▪ Members who do not receive	▪ Required for certain drugs (See Formulary)

Table 5.2: Health Partners Medicare Special (HMO SNP) 2019 Benefits Cost sharing in this plan depends on the member's Medicaid eligibility level.		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	Full extra Help will pay no more than 25% coinsurance (Specialty drugs are not available by mail order) ▪ If member receives Full Extra Help the coverage gap stage does not apply. If member Does Not receive full extra help after total drug costs (including what our plan has paid and what you have paid) reaches $3,820, you will pay no more than 37% coinsurance for generic drugs or 25% coinsurance for brand name drugs, for any drug tier during the Coverage Gap ▪ Once the member reaches the catastrophic phase with a total out of pocket expense of $5,100, Full Extra Help members pay $0 copay If member Does Not receive Full Extra Help member pays the greater of 5% coinsurance or $3.40 for generic drugs (including brand drugs treated as generic) or $8.50 for all other drugs.	
Preventive Services	▪ $0 copay for Medicare-covered services	▪ No
Prosthetic Devices	▪ 0% or 20%	▪ Yes, Over $500
Therapeutic Radiology	▪ 0% or 20% coinsurance PCP or Specialist coinsurance also applies if service is provided during an office visit	▪ Yes (Contact eviCore)
Skilled Nursing Facility (SNF)	▪ Up to 100 days each benefit period; – $0 for Days 1-20: $0 copay per day;	▪ Yes (No prior hospital stay required)

Table 5.2: Health Partners Medicare Special (HMO SNP) 2019 Benefits Cost sharing in this plan depends on the member's Medicaid eligibility level.		
Benefit/Service	**Cost-sharing/Limits**	**Prior Authorization**
	– Days 21-100: $170.50 copay per day	
Substance Abuse Treatment (Outpatient)	▪ 0% or 20% coinsurance	▪ Yes (Contact Magellan Behavioral Health)
Transportation (Routine)	▪ $0 copay ▪ Up to 60 one way van or medical transport trips each year to plan approved locations	▪ Yes
Urgently Needed Care	▪ 0% or 20% coinsurance for each Medicare-covered visit (up to $65).	▪ No
Vision Services	▪ 0% or 20% coinsurance for exam to diagnose and treat diseases and conditions of the eye ▪ $0 copay for one routine eye exam per year; ▪ One pair of eyeglasses or contact lenses every year, up to $200 limit per year. ▪ $0 copay for eyewear after cataract surgery	▪ No

** Medicare cost-sharing includes copayments, coinsurance and deductibles. Health Partners Medicare Special member's cost-sharing responsibility is based on their category of Medicaid eligibility. Medicaid will pay the Medicare Part A and B service cost-sharing for any Full Dual Eligible members, so long as the benefit is covered by both Medicare & Medicaid. Medicaid will cover Medicare cost sharing up to the difference between the Medicare paid amount and the Medicaid rate for the service. If the Medicaid rate is lower than the Medicare rate, Medicaid may not remit payment and the provider will be considered paid in full.*

Coverage of the Medicaid benefits are now being administered by Medicaid Managed Care Organizations referred to as Community HealthChoices plans (CHC). Providers should bill any remaining Medicare cost-sharing to the member's CHC for remittance of payment.

As the member's Medicare provider, you are not obligated to participate in the CHC's network in order to submit claims.

Please note, Federal law prohibits the billing of any Medicare Part A & B cost-sharing if a member's Medicaid category is Qualified Medicare Beneficiary Plus (QMB Plus); therefore, you are never to bill a QMB Plus member for Medicare Part A & B cost-sharing, even if the service is not covered by Medicaid.

Non-Covered Services

The following services and benefits are excluded or limited under Health Partners Medicare plans.

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, including care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home (limited exceptions).

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, fillings or dentures, except for services specifically covered in the Health Partners Medicare Prime and Special plans, as shown in the charts in this chapter. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, except for services specifically covered in the Health Partners Medicare Special plan, as shown in the chart in this chapter.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines, except for services specifically covered in the Health Partners Medicare Special plan, as shown in the chart in this chapter.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids or exams to fit hearing aids, except for services specifically covered in the Health Partners Medicare Special plan, as shown in the chart in this chapter.
- Eyeglasses, except as specifically covered in the Health Partners Medicare Prime and Special plans, as shown in the charts in this chapter. (However, eyeglasses are covered for people after cataract surgery.) Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Acupuncture, except for services specifically covered in the Health Partners Medicare Special plan, as shown in the chart in this chapter.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

- Drugs used to treat anorexia, weight loss, or weight gain, even if used for a non-cosmetic purpose (e.g., morbid obesity).
- Drugs used to promote fertility.
- Drugs used for cosmetic purposes or hair growth.
- Drugs used to treat symptomatic relief of cough and colds, including over-the-counter (OTC) medications.
- Prescription vitamin and mineral products, except prenatal vitamins and fluoride preparations.
- Covered outpatient drugs which the manufacturer seeks to require, as a condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.
- Agents used to treat sexual or erectile dysfunction except when prescribed to treat medically accepted indications other than sexual dysfunction or erectile dysfunction.
- Non-prescription drugs, such as over-the-counter (OTC) products except the items used in the administration of insulin. Please note that members in the Health Partners Medicare Special plan have a benefit providing an over-the-counter allowance of $50 per month for plan-specified OTC medications when obtained with a prescription.

The plan will not cover the excluded services listed above. Even if received at an emergency facility, the excluded services are still not covered.