HealthPartners Journey Dash (PPO) offered by HealthPartners, Inc. (HPI)

Annual Notice of Changes for 2023

You are currently enrolled as a member of HealthPartners Journey Dash. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

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

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

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

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

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

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

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

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

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

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

Additional Resources

- Please contact our Member Services number at 952-883-6655 or 866-233-8734 for additional information. (TTY users should call 711.) Hours are:

  From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative.

  From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT, **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.
- This information is available in a different format, including large print. Please call Member Services if you need plan information in another format.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About HealthPartners Journey Dash

- HealthPartners is a PPO plan with a Medicare contract. Enrollment in HealthPartners depends on contract renewal.
- When this document says "we," "us," or "our", it means HealthPartners, Inc. When it says "plan" or "our plan," it means HealthPartners Journey Dash.

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Annual Notice of Changes for 2023
Table of Contents

Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for HealthPartners Journey Dash in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$89.00	$85.00
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered services. (See Section 1.2 for details.)	From network providers: $3,200 From network and out-of-network providers combined: $5,150	From network providers: $3,000 From network and out-of-network providers combined: $5,150
Doctor office visits	Primary care visits: In-Network: $0 copay per visit Out-of-Network: $50 copay per visit Specialist visits: In-Network: $25 copay per visit Out-of-Network: $50 copay per visit	Primary care visits: In-Network: $0 copay per visit Out-of-Network: $50 copay per visit Specialist visits: In-Network: $25 copay per visit Out-of-Network: $50 copay per visit
Inpatient hospital stays	In-Network: $200 copay per stay Out-of-Network: 20% of the total cost	In-Network: $200 copay per stay Out-of-Network: 20% of the total cost

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $300 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 per prescription • Drug Tier 2: $10 per prescription • Drug Tier 3: $47 per prescription • Drug Tier 4: 40% of the total cost • Drug Tier 5: 27% of the total cost	Deductible: $250 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 per prescription • Drug Tier 2: $10 per prescription • Drug Tier 3: $47 per prescription • Drug Tier 4: 40% of the total cost • Drug Tier 5: 27% of the total cost

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$89.00	$85.00

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving "Extra Help" with your prescription drug costs. Please see Section 5 regarding "Extra Help" from Medicare.

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

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

Cost	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,200	$3,000 Once you have paid $3,000 out-of-pocket for covered services, you will pay nothing for your covered services from network providers for the rest of the calendar year.

Cost	2022 (this year)	2023 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$5,150	$5,150 Once you have paid $5,150 out-of-pocket for covered services, you will pay nothing for your covered services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

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

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

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

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

Section 1.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Acupuncture (In-Network and Out-of-Network)		
• Non-Medicare covered acupuncture	There is no visit limit for non-Medicare covered acupuncture services.	Non-Medicare covered acupuncture services are limited to 20 visits per calendar year combined In-Network and Out-of-Network.
Chiropractic services (Out-of-Network)	You pay a $25 copay per visit.	You pay a $20 copay per visit.
Dental services (In-Network and Out-of-Network)		
• Preventive and Comprehensive Dental Services	The combined In-Network and Out-of-Network calendar year maximum benefit for covered dental services is $1,000.	The combined In-Network and Out-of-Network calendar year maximum benefit for covered dental services is $2,250.

Cost	2022 (this year)	2023 (next year)
	There are no frequency limits on covered dental services.	The following frequency limits apply to covered dental services: • Dental screenings are limited to once per year. • Routine dental exams are limited to twice per year. • Teeth cleaning (prophylaxis or periodontal maintenance recall) is limited to twice per year. • Bitewing x-rays are limited to once per year. • Full-mouth (panoramic) x-rays are limited to once every three years. • Fluoride treatment is limited to twice per year. • Sealants are limited to once every three years. • Special restorative care - Replacement of crowns, inlays, and onlays is limited to once every five years. • Non-surgical periodontics (gum disease) are limited to once every two years. • Surgical periodontics (gum disease) are limited to once every two years.
	If you receive services from an Out-of-Network dental provider, you are not responsible for the difference between the billed charge and the usual and customary allowed amount.	If you receive services from an Out-of-Network dental provider, in addition to any copayment or coinsurance, you will be responsible for the difference between the billed charge and the usual and customary allowed amount.

Cost	2022 (this year)	2023 (next year)
HealthPartners Choice Card The HealthPartners Choice Card is a prepaid MasterCard® that includes an annual benefit maximum that you may use toward coverage of the non-Medicare covered items and services described below. You may choose to use for any one item or service or a combination of these items and services. • Routine chiropractic services for the conservative management of neuromusculoskeletal disorders and related functional clinical conditions. • Prescription eyewear, including eyeglasses (frames and lenses), upgrades, and/or contact lenses. • TruHearing brand hearing aids through the plan's hearing aid benefit. See the *Evidence of Coverage* for further details and limitations. You will automatically be mailed the Choice Card in January. If you do not receive your card, please contact Member Services.	The Choice Card is not covered.	You pay a $0 copay for covered Choice Card items and services up to the annual benefit maximum of $500. You pay all costs over $500. Once the card is exhausted, you will be responsible for the entire cost of items and services not otherwise covered. To be covered, items and services must be provided by practitioners and facilities who are not excluded from or have not opted out of receiving payment from Medicare and who are licensed (when applicable) in the state where they perform services.

Cost	2022 (this year)	2023 (next year)
Hearing services		
• TruHearing Hearing Aids	This benefit is limited to TruHearing's Advanced and Premium hearing aids. You pay a: • $599 copay per aid for Advanced aids • $899 copay per aid for Premium Aids Premium hearing aids are available in rechargeable style options for an additional $50 per aid.	This benefit is limited to TruHearing's Standard, Advanced and Premium hearing aids. You pay a: • $399 copay per aid for Standard Aids • $599 copay per aid for Advanced Aids • $899 copay per aid for Premium Aids Advanced and Premium hearing aids are available in rechargeable style options for an additional $50 per aid. Members have the option of using their HealthPartners Choice Card benefit toward the above costs. See the *Evidence of Coverage* for further details.
Outpatient hospital observation (In-Network)	You pay a $0 copay per day.	You pay a $175 copay per day.
Skilled nursing facility (SNF) care (In-Network)	You pay a $0 copay per day for days 1-20. You pay a $188 copay per day for days 21-100.	You pay a $0 copay per day for days 1-20. You pay a $196 copay per day for days 21-100.

Cost	2022 (this year)	2023 (next year)
Vision care (In-Network and Out-of-Network)		
• Non-Medicare covered prescription eyewear	You pay a $0 copay and all charges over $150 per calendar year. The calendar year maximum benefit is combined for In-Network and Out-of-Network benefits.	Coverage is under the HealthPartners Choice Card benefit. See HealthPartners Choice Card for more information.

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

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

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

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

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

Changes to Prescription Drug Costs

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

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

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 4 (Non-preferred Drugs) and Tier 5 (Specialty Drugs) drugs until you have reached the yearly deductible.	The deductible is $300. During this stage, you pay $0 cost sharing for drugs on Tier 1 (Preferred Generic Drugs), $10 cost sharing for drugs on Tier 2 (Generic Drugs), and the full cost of drugs on Tier 3 (Preferred Brand Drugs), Tier 4 (Non-preferred Drugs) and Tier 5 (Specialty Drugs) until you have reached the yearly deductible.	The deductible is $250. During this stage, you pay $0 cost sharing for drugs on Tier 1 (Preferred Generic Drugs), $10 cost sharing for drugs on Tier 2 (Generic Drugs), $47 cost sharing for drugs on Tier 3 (Preferred Brand Drugs), and the full cost of drugs on Tier 4 (Non-preferred Drugs) and Tier 5 (Specialty Drugs) until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.**	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic Drugs):** You pay $0 per prescription. **Tier 2 (Generic Drugs):** You pay $10 per prescription. **Tier 3 (Preferred Brand Drugs):** You pay $47 per prescription. **Tier 4 (Non-preferred Drugs):** You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** You pay 27% of the total cost. _____	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 (Preferred Generic Drugs):** You pay $0 per prescription. **Tier 2 (Generic Drugs):** You pay $10 per prescription. **Tier 3 (Preferred Brand Drugs):** You pay $47 per prescription. **Tier 4 (Non-preferred Drugs):** You pay 40% of the total cost. **Tier 5 (Specialty Drugs):** You pay 27% of the total cost. _____

Stage	2022 (this year)	2023 (next year)
Stage 2: Initial Coverage Stage (continued)		
The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).	Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.

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

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

Additional Resources to Help – Please contact our Member Services number at 952-883-6655 or 866-233-8734 for additional information. (TTY users should call 711.) Hours are:

From **Oct. 1 through March 31**, we take calls from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative.

From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT, **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in HealthPartners Journey Dash

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

Section 2.2 – If you want to change plans

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

Step 1: Learn about and compare your choices

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

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

As a reminder, HealthPartners, Inc. offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

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

SECTION 3 Deadline for Changing Plans

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

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

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

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

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

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Minnesota, the SHIP is called Senior LinkAge Line®.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Senior LinkAge Line counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Senior LinkAge Line at 1-800-333-2433. You can learn more about Senior LinkAge Line by visiting their website (https://mn.gov/senior-linkage-line/).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

  - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the AIDS Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Minnesota Department of Human Services at 651-431-2414 or 800-657-3761.

SECTION 6 Questions?

Section 6.1 – Getting Help from our plan

Questions? We're here to help. Please call Member Services at 952-883-6655 or 866-233-8734. (TTY only, call 711.) We are available for phone calls **Oct. 1 through March 31** from 8 a.m. to 8 p.m. CT, **seven days a week**. You'll speak with a representative. From **April 1 through Sept. 30**, call us 8 a.m. to 8 p.m. CT, **Monday through Friday** to speak with a representative. On Saturdays, Sundays and Federal holidays, you can leave a message and we'll get back to you within one business day.

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

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2023. For details, look in the *2023 Evidence of Coverage* for our plan. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at **healthpartners.com/medicare**. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

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

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

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

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

Visit the Medicare Website

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

Read *Medicare & You 2023*

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