Provider Partners Health Plans

Summary of Benefits 2025

Provider Partners Indiana Community Plan (HMO I-SNP) (H4444-002)
Provider Partners Maryland Community Plan (HMO I-SNP) (H8067-003)
Provider Partners Missouri Community Plan (HMO I-SNP) (H9191-004)
Provider Partners North Carolina Community Plan (HMO I-SNP) (H4439-002)
Provider Partners Pennsylvania Community Plan (HMO I-SNP) (H4093-004)

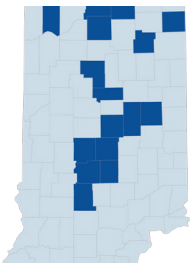
This is a summary of drug and health services covered by Provider Partners Health Plans (HMO I-SNP) for the plan year: January 1, 2025 - December 31, 2025. This plan, Provider Partners Indiana Community Plan, Provider Partners Maryland Community Plan, Provider Partners Missouri Community Plan, Provider Partners North Carolina Community Plan, Provider Partners Pennsylvania Community Plan, is offered by Provider Partners Health Plans. When this Summary of Benefits says "we," "us," or "our," it means Provider Partners Health Plans. When it says "plan" or "our plan," it means Provider Partners Indiana Community Plan, Provider Partners Maryland Community Plan, Provider Partners Missouri Community Plan, Provider Partners North Carolina Community Plan, Provider Partners Pennsylvania Community Plan.

Provider Partners Health Plans (HMO I-SNP) is a Health Maintenance Organization (HMO) Special Needs plan (SNP) with a Medicare contract. Enrollment in Provider Partners Health Plans depends on contract renewal.

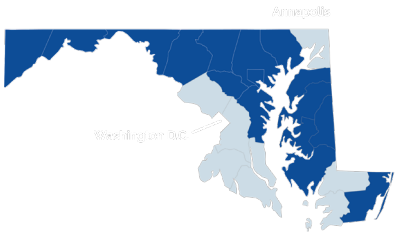
Benefits, premiums and/or copayments/co-insurance may change on January 1 of each year. Limitations, copayment, and restrictions may apply. This information is not a complete description of benefits. A complete list of benefits is available in the Evidence of Coverage. Call Member Services at 1-800-405-9681/TTY 711 for more information or visit our website at www.pphealthplan.com.

To join Provider Partners Health Plans (HMO I-SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live at home and your state of residence has certified that you need the type of care that is usually provided in a nursing home. You must continue to pay your Medicare Part B Premium.

Our service area includes the following counties in **Indiana (IN):** Cass, DeKalb, Delaware, Elkhart, Hamilton, Hendricks, Howard, Johnson, Madison, Marion, Marshall, Monroe, Morgan, Porter, St. Joseph, Vanderburgh, Warrick, and Whitley.

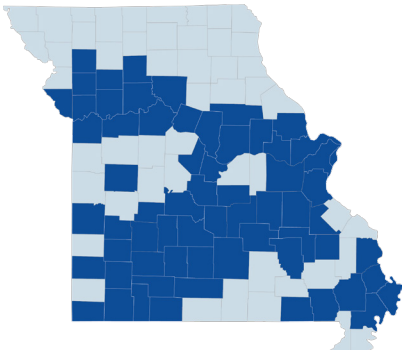


Our service area includes the following counties in **Maryland (MD)**: Allegany, Anne Arundel, Baltimore, Baltimore City, Caroline, Carroll, Dorchester, Frederick, Garrett, Harford, Howard, Kent, Queen Anne's, Talbot, Washington, and Worcester.

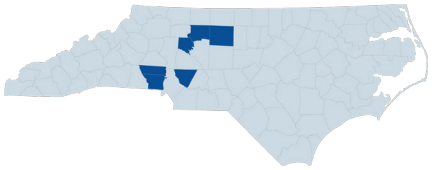


Our service area includes the following counties in **Missouri (MO)**: Audrain, Barry, Boone, Butler, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Cedar, Chariton, Christian, Clay, Clinton, Cole, Crawford, Dade, Dallas, DeKalb, Dent, Douglas, Franklin, Greene, Henry, Hickory, Howard, Iron, Jackson, Jasper, Jefferson, Laclede, Lafayette, Lawrence, Lincoln, Livingston, Madison, Maries, McDonald, Miller, Mississippi, Moniteau, Montgomery, New Madrid, Phelps, Platte, Polk, Pulaski, Ray,

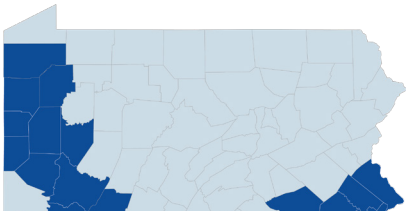
Reynolds, Ripley, Saline, Scott, St. Charles, St. Francois, St. Louis, St. Louis City, Stoddard, Stone, Taney, Texas, Vernon, Warren, Washington, Webster and Wright.



Our service area includes the following counties in **North Carolina (NC)**: Cabarrus, Davie, Forsyth, Gaston, Guilford, and Lincoln.



Our service area includes the following counties in **Pennsylvania (PA)**: Allegheny, Armstrong, Beaver, Bucks, Butler, Chester, Crawford, Delaware, Fayette, Greene, Lancaster, Lawrence, Mercer, Montgomery, Philadelphia, Somerset, and Westmoreland.



Except in emergency situations, if you use the providers that are not in our network, we may not pay for these services.

For 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), 7 days a week, 24 hours a day. TTY users should call 1-877-486-2048.

This document is available in other formats such as Braille or large print.

For more information, please call us at 1-800-405-9681 (TTY users should call 711). Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31. 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30 or visit us at www.pphealthplan.com.

Premiums and Benefits	Provider Partners Health Plans HMO I-SNP
Monthly Plan Premium *(includes both medical and drugs)*	You pay $0 You must continue to pay your Medicare Part B premium.
Deductible	You pay $0
Maximum Out-of-Pocket Responsibility *(does not include Part D prescription drugs)*	**IN:** You pay no more than $3,750 annually **MD:** You pay no more than $3,750 annually **MO:** You pay no more than $3,750 annually **NC:** You pay no more than $3,750 annually **PA:** You pay no more than $2,600 annually
Inpatient Hospital	$1,676 deductible for each benefit period. Days 1–60: $0 after you pay your Part A deductible. Days 61–90: $419 copayment each day. Days 91-150: $838 copayment each day while using your 60 lifetime reserve days. After day 150: You pay all costs. Beyond lifetime reserve days. You pay all costs. Prior authorization does apply.

Premiums and Benefits	Provider Partners Health Plans HMO I-SNP
Outpatient Hospital	You pay 20% of the total cost for Medicare-covered services Prior authorization may apply
Ambulatory Surgery Center (ASC)	You pay 20% of the total cost for Medicare-covered services. Prior authorization may apply.
Doctor Visits • Primary care • Specialists	 You pay 0% of the total cost for Medicare- covered services You pay 20% of the total cost for Medicare- covered services Prior authorization may apply
Preventive Care (e.g., flu vaccine, diabetic screenings)	You pay nothing Other preventive services are available. There are some covered services that have a cost.
Emergency Care	You pay 20% of the total cost (up to $100 maximum) per visit Coinsurance is waived if you are admitted to the same hospital within 24 hours for the same condition.
Urgently Needed Services	You pay 20% of the total cost (up to $45 maximum combined) per visit
Diagnostic Services/Labs/ Imaging • Diagnostic tests and procedures • Lab services • MRI, PET, Nuclear Medicine • X-Rays	 You pay 20% of the total cost for Medicare-covered services Prior authorization may apply. You pay 20% of the total cost for Medicare-covered services You pay 20% of the total cost for Medicare-covered services Prior authorization may apply. You pay 20% of the total cost for Medicare-covered services
Hearing Services • Routine hearing exam • Supplemental hearing aid • Medicare-covered hearing exams	 You pay 0% of the total cost for one routine hearing exam a year. **IN:** Our plan pays up to $2,000 every 2 years for hearing aids. The $2,000 amount applies to both ears combined **MD:** Our plan pays up to $2,000 every 2 years for hearing aids. The $2,000 amount applies to both ears combined **MO:** Our plan pays up to $2,000 every 2 years for hearing aids. The $2,000 amount applies to both ears combined **NC:** Our plan pays up to $2,000 every 2 years for hearing aids. The 2,000 amount applies to both ears combined **PA:** Our plan pays up to $2,000 every 2 years for hearing aids. The $2,000 amount applies to both ears combined You pay 20% of the total cost for Medicare-covered hearing services Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the routine hearing benefit.

Premiums and Benefits	Provider Partners Health Plans HMO I-SNP
Dental Services • Preventative & Comprehensive Supplemental dental services	**IN:** You pay a $0 copay for a combined annual allowance of $3,000. After the $3,000 annual allowance has been exhausted, you are responsible for any remaining charges. **MD:** You pay a $0 copay for a combined annual allowance of $3,000. After the $3,000 annual allowance has been exhausted, you are responsible for any remaining charges. **MO:** You pay a $0 copay for a combined annual allowance of $3,000. After the $3,000 annual allowance has been exhausted, you are responsible for any remaining charges. **NC:** You pay a $0 copay for a combined annual allowance of $3,000. After the $3,000 annual allowance has been exhausted, you are responsible for any remaining charges. **PA:** You pay a $0 copay for a combined annual allowance of $3,000. After the $3,000 annual allowance has been exhausted, you are responsible for any remaining charges.
• Medicare-covered dental services	You pay 20% of the total cost for Medicare-covered services Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the routine dental benefit.
Vision Services • Routine vision exam	You pay 0% of the total cost for one routine vision exam a year.
• Supplemental eyewear	**IN:** $300 maximum plan coverage amount for routine eye wear every year **MD:** $300 maximum plan coverage amount for routine eye wear every year **MO:** $300 maximum plan coverage amount for routine eye wear every year **NC:** $300 maximum plan coverage amount for routine eye wear every year **PA:** $300 maximum plan coverage amount for routine eye wear every year
• Medicare-covered eye exams	You pay 20% of the total cost of Medicare-covered services.
• Medicare-covered eyewear	You pay 20% of the total cost of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the routine vision benefit.
Mental Health Services • Inpatient visit	$1,676 deductible for each benefit period. Days 1–60: $0 after you pay your Part A deductible. Days 61–90: $419 copayment each day. Days 91-150: $838 copayment each day while using your 60 lifetime reserve days. After day 150: You pay all costs. Beyond lifetime reserve days: You pay all costs. Prior authorization does apply.
• Outpatient group therapy/ individual therapy visit	You pay 20% of the total cost for Medicare-covered services Prior authorization may apply.
Skilled Nursing Facility	**IN:** You pay $0 for Skilled Nursing Facility services Prior authorization may apply.

Premiums and Benefits	Provider Partners Health Plans HMO I-SNP
Skilled Nursing Facility (continued)	**MD:** You pay: Days 1-20: $0 copayment Days 21-100: $209.50 copayment each day Days 101 and beyond: You pay all costs Prior authorization may apply. **MO:** You pay: Days 1-20: $0 copayment Days 21-100: $209.50 copayment each day Days 101 and beyond: You pay all costs Prior authorization may apply. **NC:** You pay: Days 1-20: $0 copayment Days 21-100: $209.50 copayment each day Days 101 and beyond: You pay all costs. Prior authorization may apply. **PA:** You pay: Days 1-20: $0 copayment Days 21-100: $209.50 copayment each day Days 101 and beyond: You pay all costs. Prior authorization may apply.
Physical Therapy	You pay 0% of the total cost of Medicare-covered services. Prior authorization may apply.
Ambulance	You pay 20% of the total cost for each one-way Medicare-covered ambulance trip
Transportation	**IN:** You pay a $0 copay for up to 36 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **MD:** You pay a $0 copay for up to 14 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **MO:** You pay a $0 copay for up to 14 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **NC:** You pay a $0 copay for up to 14 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. **PA:** You pay a $0 copay for up to 14 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on this transportation benefit.
Medicare Part B Drugs	You can pay from 0% to 20% for Medicare Part B Chemotherapy/Radiation Drugs and other Medicare Part B Drugs. You can pay from 0% to 20% (with a $35 maximum) for insulin per month. Prior authorization may apply.

Added Value Benefits	
Annual Physical Exam	You pay 20% of the total cost of services.
Foot Care (podiatry services) • Routine foot care	**IN:** You pay $0 copay for up to 4 routine visits every year **MD:** You pay $0 copay for up to 4 routine visits every year **MO:** You pay $0 copay for up to 5 routine visits every year **NC:** You pay $0 copay for up to 6 routine visits every year **PA:** You pay $0 copay for up to 4 routine visits every year
• Medicare-covered foot care	You pay 20% of the total cost for Medicare-covered services Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the routine podiatry benefit.
Over-the-Counter (OTC) Benefit	Limited to allowance every quarter for specific over-the-counter drugs and other health-related products, as listed in the OTC catalog. **IN:** $50 allowance every quarter **MD:** $55 allowance every quarter **MO:** $50 allowance every quarter **NC:** $50 allowance every quarter **PA:** $50 allowance every quarter OTC items may be purchased only for the member and are limited to one order every quarter. Any unused benefit expires at the end of the quarter and cannot be carried over to the next quarter. Call Member Services or refer to the Evidence of Coverage, Chapter 4 for more information on the over-the-counter benefit.
Special Supplemental Benefits for the Chronically Ill - Grocery Benefit*	**IN:** $25 allowance every month **MD:** $60 allowance every month **MO:** $60 allowance every month **NC:** $60 allowance every month **PA:** $60 allowance every month *These are special supplemental benefits, not all members will qualify. Members that have been diagnosed with one or more of the following chronic conditions AND meet certain criteria may be eligible for these benefits: cardiovascular disorders, chronic heart failure, dementia, diabetes and chronic and disabling mental health conditions. Other conditions may also make you eligible for these benefits. Funds are made available to you via a restricted spend prepaid debit card** for use at participating retail locations. Members can purchase healthy foods and prepared meals. Any unused funds do not rollover to the next period. **&more Benefits Prepaid Mastercard® is issued by Avidia Bank, pursuant to a license from Mastercard Inc. Use of this card is subject to the terms and conditions of the Cardholder Agreement. Call Member Services or refer to the Evidence of Coverage, Chapter 3 for more information on the Grocery Benefit.

Pharmacy	Prescription Drug Benefits	
Deductible	You pay $590	
	Standard Retail Rx 30-day supply	Mail Order 30-day supply
Initial Coverage Tier 1: All Part D Covered Drugs	You pay 25% of the total cost of the drug You pay $35 per month supply of each covered insulin product on this tier.	You pay 25% of the total cost of the drug You pay $35 per month supply of each covered insulin product on this tier.
Vaccine Tier	You pay $0 for pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. For further information about vaccines, please reference the Evidence of Coverage.	
Catastrophic Coverage *(after you or others on your behalf pay $2,000)* • Generic Drugs • Brand-Name Drugs	 You Pay Nothing You Pay Nothing	

NOTICE OF NON-DISCRIMINATION

Provider Partners Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). Provider Partners Health Plans does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Provider Partners Health Plans:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Provider Partners Health Plans Compliance Officer.

If you believe that Provider Partners Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Provider Partners Health Plans Compliance Officer
Mailing Address: 785 Elkridge Landing Rd, Suite #300
Linthicum Heights, MD 21090
Phone: 1-833-213-0636
Fax: 1-844-570-7811
Email: compliance@pphealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Provider Partners Health Plans Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at Provider Partners Health Plans website: **www.pphealthplan.com**

MULTI-LANGUAGE INTERPRETIVE SERVICE

Form Approved
OMB# 0938-1421

English
We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-405-9681. Someone who speaks English/ Language can help you. This is a free service.

Español (Spanish)
Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-405-9681. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

(Chinese Mandarin) 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电1-800-405-9681.我们的中文工作人员很乐意帮助您。这是一项免费服务。

(Chinese Cantonese) 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-405-9681。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog (Tagalog)
Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-405-9681. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Français (French)
Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-405-9681. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Tiếng Việt (Vietnamese)
Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-405-9681 (TTY 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

(German) Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-405-9681. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

한국어 (Korean)
당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-405-9681.번으로문의해주십시오. 한국어를하는담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Русский (Russian)
Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-405-9681.Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

(Arabic) العربية
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-405-9681. هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية بمساعدتك.

(Hindi) हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-405-9681. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

(Italian) È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-405-9681. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português (Portugese)
Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-405-9681. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

Kreyòl Ayisyen (French Creole)
Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-405-9681. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polski (Polish)
Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-405-9681. Ta usługa jest bezpłatna.

(Japanese) 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには 1-800-405-9681.にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。