2016

Summary of Benefits

Health Partners Medicare Basic/Prime/PrimePlus (HMO)

Health Partners Plans

Health Partners Medicare Basic (HMO)
Health Partners Medicare Prime (HMO)
Health Partners Medicare PrimePlus (HMO)

(a Medicare Advantage Health Maintenance Organization (HMO) offered by Health Partners Plans, Inc. with a Medicare contract)

Summary of Benefits
January 1, 2016 - December 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Health Partners Medicare).

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what Health Partners Medicare plans cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.
- 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 http://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.

SECTIONS IN THIS BOOKLET

- Things to Know About Health Partners Medicare Basic/Prime/PrimePlus (HMO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at 1-866-901-8000 (TTY 711).

Este documento podría estar disponible en otros formatos como Braille y letra grande. Este documento podría estar disponible en otro idioma que no sea inglés. Para obtener información adicional, llámenos al 1-866-901-8000 (TTY 711).

THINGS TO KNOW ABOUT HEALTH PARTNERS MEDICARE BASIC/PRIME/PRIMEPLUS (HMO)

HOURS OF OPERATION

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

HEALTH PARTNERS MEDICARE PHONE NUMBERS AND WEBSITE

- If you are a member of this plan, call toll-free 1-866-901-8000 (TTY 711).
- If you are not a member of this plan, call toll-free 1-866-901-8000 (TTY 711).
- Our website: HPPMedicare.com

WHO CAN JOIN?

To join Health Partners Medicare Basic/Prime/PrimePlus (HMO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Pennsylvania: Bucks, Chester, Delaware, Montgomery and Philadelphia.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Health Partners Medicare has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's Provider & Pharmacy Directory at our website (HPPMedicare.com).

Or, call us and we will send you a copy of the Provider & Pharmacy Directory.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

Our Prime and PrimePlus plans cover Part D drugs. In addition, all our plans cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, HPPMedicare.com.

Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plan groups each medication into one of four "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Health Partners Medicare is an HMO plan with Medicare and Pennsylvania State Medicaid program contracts. Enrollment in Health Partners Medicare depends on contract renewal.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	$0 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
Please refer to the Premium Table on page 29 to find out the premium in your area. In addition, you must keep paying your Medicare Part B premium.	Please refer to the Premium Table on page 29 to find out the premium in your area. In addition, you must keep paying your Medicare Part B premium.
$300 per year for Part D prescription drugs except for drugs listed on Tier 1 which are excluded from the deductible.	This plan has deductibles for some hospital and medical services. This plan does not have a deductible for Part D prescription drugs.
Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Covered Medical and Hospital Benefits Notes: • Services with a [1] may require prior authorization.	
Outpatient Care and Services	
Acupuncture	Not covered
Ambulance[1]	$225 copay
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $50 copay Medicare-covered benefits only. No supplemental preventive services (such as cleanings) are covered.

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
Not covered	For up to 20 visit(s) every year: $5 copay Services must be received from network providers.
$225 copay	$175 copay
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 copay Routine chiropractic visit (for up to 20 every year): $20 copay
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $50 copay Medicare-covered benefits only. No supplemental preventive services (such as cleanings) are covered.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): $35 copay after you pay your deductible. Preventive dental services: • Cleaning (for up to 2 every year): $0 copay • Dental x-ray(s) (for up to 1 every year): $0 copay • Fluoride treatment (for up to 1 every year): $0 copay • Oral exam (for up to 2 every year): $0 copay Plan also offers $800 annually toward restorative dental services. $50 deductible applies to these services only.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Diabetes Supplies and Services	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1] *(Costs for these services may vary based on place of service)*	Diagnostic radiology services (such as MRIs, CT scans): $200 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: $40 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost Outpatient x-ray copay may also apply to some diagnostic radiology services. Copays/coinsurance relate to specific services. If you receive different services during one visit, you may be required to pay *more than one* copay or coinsurance amount.
Doctor's Office Visits[1]	Primary care physician visit: You pay nothing Specialist visit: $50 copay Copays/coinsurance relate to specific services. If you receive different services during one visit, you may be required to pay *more than one* copay or coinsurance amount.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
Diabetes Supplies and Services	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost	Diabetes monitoring supplies: 0-20% of the cost, depending on the supply Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1] *(Costs for these services may vary based on place of service)*	Diagnostic radiology services (such as MRIs, CT scans): $225 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: $35 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost Outpatient x-ray copay may also apply to some diagnostic radiology services. Copays/coinsurance relate to specific services. If you receive different services during one visit, you may be required to pay *more than one* copay or coinsurance amount.	Diagnostic radiology services (such as MRIs, CT scans): $195 copay Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: $20 copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost Outpatient x-ray copay may also apply to some diagnostic radiology services. Copays/coinsurance relate to specific services. If you receive different services during one visit, you may be required to pay *more than one* copay or coinsurance amount.
Doctor's Office Visits[1]	Primary care physician visit: You pay nothing Specialist visit: $50 copay Copays/coinsurance relate to specific services. If you receive different services during one visit, you may be required to pay *more than one* copay or coinsurance amount.	Primary care physician visit: You pay nothing Specialist visit: $35 copay Copays/coinsurance relate to specific services. If you receive different services during one visit, you may be required to pay *more than one* copay or coinsurance amount.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	20% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. You must get prior authorization from the plan for Durable Medical Equipment that costs more than $500.
Emergency Care	$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $50 copay Medicare-covered benefits only. No supplemental foot care is covered.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $50 copay Routine hearing exam (for up to 1 every year): $0 copay Hearing aids not covered.

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
20% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. You must get prior authorization from the plan for Durable Medical Equipment that costs more than $500.	20% of the cost If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors. You must get prior authorization from the plan for Durable Medical Equipment that costs more than $500.
$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$65 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $50 copay Medicare-covered benefits only. No supplemental foot care is covered.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 copay Routine foot care (for up to 1 visit every three months): $35 copay
Exam to diagnose and treat hearing and balance issues: $50 copay Routine hearing exam (for up to 1 every year): $0 copay Hearing aids not covered.	Exam to diagnose and treat hearing and balance issues: $35 copay Routine hearing exam (for up to 1 every year): $0 copay Hearing aid: $0 copay You are covered up to $1,000 every 3 years for hearing aids.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Home Health Care[1]	You pay nothing
Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 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. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $215 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 Outpatient group therapy visit: $40 copay Outpatient individual therapy visit: $40 copay

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
You pay nothing	You pay nothing
Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 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. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $215 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 Outpatient group therapy visit: $40 copay Outpatient individual therapy visit: $40 copay	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers 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. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. • $200 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $35 copay Outpatient individual therapy visit: $35 copay

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Outpatient Rehabilitation[1]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $50 copay Occupational therapy visit: $40 copay Physical therapy and speech and language therapy visit: $40 copay
Outpatient Substance Abuse[1]	Group therapy visit: $50 copay Individual therapy visit: $50 copay
Outpatient Surgery[1]	Ambulatory surgical center: $180 copay Outpatient hospital: $250 copay Copays relate to specific services. If you receive different services during one visit, you may be required to pay more than one copay.
Over-the-Counter Items	Not covered
Prosthetic Devices (braces, artificial limbs, etc.)[1]	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost You must get prior authorization from the plan for most prosthetic devices.

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $50 copay Occupational therapy visit: $40 copay Physical therapy and speech and language therapy visit: $40 copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $35 copay Occupational therapy visit: $35 copay Physical therapy and speech and language therapy visit: $35 copay
Group therapy visit: $50 copay Individual therapy visit: $50 copay	Group therapy visit: $35 copay Individual therapy visit: $35 copay
Ambulatory surgical center: $200 copay Outpatient hospital: $275 copay Copays relate to specific services. If you receive different services during one visit, you may be required to pay more than one copay.	Ambulatory surgical center: $165 copay Outpatient hospital: $200 copay Copays relate to specific services. If you receive different services during one visit, you may be required to pay more than one copay.
Not covered	Not covered
Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost You must get prior authorization from the plan for most prosthetic devices.	Prosthetic devices: 20% of the cost Related medical supplies: 20% of the cost You must get prior authorization from the plan for most prosthetic devices.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Renal Dialysis	20% of the cost
Transportation	Not covered
Urgently Needed Services	$45 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $50 copay Routine eye exam (for up to 1 every year): $0 copay Eyeglasses or contact lenses after cataract surgery: You pay nothing Eyeglasses and contact lenses are not covered by this plan, except as noted above. No supplemental coverage.

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
20% of the cost	20% of the cost
Not covered	Not covered
$45 copay	$35 copay
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $50 copay Routine eye exam (for up to 1 every year): $0 copay Eyeglasses or contact lenses after cataract surgery: You pay nothing Eyeglasses and contact lenses are not covered by this plan, except as noted above. No supplemental coverage.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $35 copay Routine eye exam (for up to 1 every year): $0 copay Contact lenses (for up to 1 every two years): $0 copay Eyeglasses (frames and lenses) (for up to 1 every two years): $0 copay Eyeglass frames (for up to 1 every two years): $0 copay Eyeglass lenses (for up to 1 every two years): $0 copay Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $200 every two years for eyewear. $200 limit applies to all contact lenses, eyeglasses, frames and lenses listed above EXCEPT those provided after cataract surgery.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Preventive Care	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • “Welcome to Medicare” preventive visit (one-time) • Yearly “Wellness” visit Any additional preventive services approved by Medicare during the contract year will be covered.

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)	Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Inpatient Care			
Inpatient Hospital Care[1]	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $260 copay per day for days 1 through 7 • You pay nothing per day for days 8 through 90 • You pay nothing per day for days 91 and beyond	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $295 copay per day for days 1 through 6 • $180 copay per day for day 7 • You pay nothing per day for days 8 through 90 • You pay nothing per day for days 91 and beyond	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $225 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $156.50 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $156.50 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20 • $156.50 copay per day for days 21 through 100

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	Health Partners Medicare Basic (HMO)
Prescription Drug Benefits	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost Our plan does not cover Part D prescription drugs.
Initial Coverage	
Standard Retail Cost-Sharing	

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost
	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.	You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

Tier	*One-month supply*	*Two-month supply*	*Three-month supply*
Tier 1 (Generic)	$7 copay	$14 copay	$14 copay
Tier 2 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 3 (Non-Preferred Brand)	$95 copay	$190 copay	$190 copay
Tier 4 (Specialty Tier)	26% of the cost	Not offered	Not offered

Tier	*One-month supply*	*Two-month supply*	*Three-month supply*
Tier 1 (Generic)	$7 copay	$14 copay	$14 copay
Tier 2 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 3 (Non-Preferred Brand)	$95 copay	$190 copay	$190 copay
Tier 4 (Specialty Tier)	33% of the cost	Not offered	Not offered

	Health Partners Medicare Basic (HMO)
Standard Mail Order Cost-Sharing	

Health Partners Medicare Prime (HMO)			Health Partners Medicare PrimePlus (HMO)		
Tier	***One-month supply***	***Three-month supply***	***Tier***	***One-month supply***	***Three-month supply***
Tier 1 (Generic)	Not offered	$14 copay	Tier 1 (Generic)	Not offered	$14 copay
Tier 2 (Preferred Brand)	Not offered	$90 copay	Tier 2 (Preferred Brand)	Not offered	$90 copay
Tier 3 (Non-Preferred Brand)	Not offered	$190 copay	Tier 3 (Non-Preferred Brand)	Not offered	$190 copay
Tier 4 (Specialty Tier)	26% of the cost	Not offered	Tier 4 (Specialty Tier)	33% of the cost	Not offered
If you reside in a long-term care facility, you pay the same as at a retail pharmacy.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy.		
You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.			You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.		
The $300 deductible does not apply to generic drugs, but during the deductible stage you must pay the cost-sharing shown above for generic drugs.					

Summary of Benefits
Health Partners Medicare

	Health Partners Medicare Basic (HMO)
Coverage Gap	
Catastrophic Coverage	

Summary of Benefits
Health Partners Medicare

Health Partners Medicare Prime (HMO)	Health Partners Medicare PrimePlus (HMO)
Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

Health Partners Plans

Multi-language Interpreter Services

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 1-866-901-8000. Someone who speaks English/Language can help you. This is a free service.

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 1-866-901-8000. 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 1-866-901-8000。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 1-866-901-8000。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: 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 1-866-901-8000. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

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 1-866-901-8000. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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 1-866-901-8000 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 1-866-901-8000. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-866-901-8000 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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 1-866-901-8000. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات الترجمة الفورية المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-866-901-8000. سيقوم شخص يتحدث اللغة العربية بمساعدتك .هذه خدمة مجانية.

Hindi: हमारी स्वास्थ्य या दवा संबंधी योजना के बारे में आपके किसी भी प्रश्न का जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवा उपलब्ध है। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-866-901-8000 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 1-866-901-8000. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: 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 1-866-901-8000. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

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 1-866-901-8000. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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 1-866-901-8000. 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、1-866-901-8000 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。**

Summary of Benefits
Health Partners Medicare

Please see the table below to find the premium for the county where you live.

Cost-sharing does not vary by county.
See the copay, coinsurance and deductible information shown throughout this *Summary of Benefits* to find out your other costs as a member of Health Partners Medicare (H9207).

Premium Table for Health Partners Medicare Prime and PrimePlus

If you have any questions about these plans, please call 1-866-901-8000 (TTY 711).

Health Partners Medicare Prime (Plan 002) – *Philadelphia County:*	**Health Partners Medicare PrimePlus (Plan 003) – *Philadelphia County:***
Your monthly plan premium is $10 per month. In addition, you must keep paying your Medicare Part B premium.	Your monthly plan premium is $95 per month. In addition, you must keep paying your Medicare Part B premium.
Health Partners Medicare Prime (Plan 005) – *Bucks, Chester, Delaware and Montgomery Counties:*	**Health Partners Medicare PrimePlus (Plan 006) – *Bucks, Chester, Delaware and Montgomery Counties:***
Your monthly plan premium is $35 per month. In addition, you must keep paying your Medicare Part B premium.	Your monthly plan premium is $110 per month. In addition, you must keep paying your Medicare Part B premium.

Health Partners Medicare
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Visit us at HPPMedicare.com

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