



# Your family Our focus

2017 Summary of Benefits  
**Health Partners Medicare  
Basic, Value and  
Prime (HMO) Plans**



**Health Partners** Plans

## **Health Partners Medicare (H9207)**

### **Health Partners Medicare Basic (HMO) (plan 001)**

### **Health Partners Medicare Value (HMO) (plans 007 and 008)**

### **Health Partners Medicare Prime (HMO) (plans 002 and 005)**

This is a summary of drug and health services covered by Health Partners Medicare Basic, Health Partners Medicare Value and Health Partners Medicare Prime for the plan year: January 1, 2017 – December 31, 2017.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the “Evidence of Coverage.”

This information is available for free in other languages. This document is available in other formats such as Braille and large print. Please call our Member Relations number at 1-866-901-8000 (TTY 711), 24 hours a day, seven days a week.

Esta información está disponible sin costo en otros idiomas. Este documento podría estar disponible en otros formatos como Braille y letra grande. Llame a nuestro número de teléfono de Servicios para Miembros al 1-866-901-8000 (TTY 711), las 24 horas del día, los siete días de la semana.

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

For information about prescription drugs covered, please see the plan's Formulary. For information about providers and pharmacies in our network, see our Provider & Pharmacy Directory. These documents are available at [www.HPPMedicare.com](http://www.HPPMedicare.com) or by calling the plan at 1-866-901-8000 (TTY 711). You can call 24 hours a day, seven days a week.

To join Health Partners Medicare Basic, Health Partners Medicare Value or Health Partners Medicare Prime, 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.

To learn 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, seven days a week. TTY users should call 1-877-486-2048.

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

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)
Monthly Plan Premium	You pay \$0	You pay \$0
Deductible	You pay \$0	You pay \$0
Maximum Out-of-Pocket Responsibility ( <i>does not include prescription drugs</i> )	\$6,700 annually	\$6,700 annually
Inpatient Hospital Coverage	You pay a \$260 copay each day for days 1-7; \$0 copay each day for days 8+	You pay a \$295 copay each day for days 1-6; \$180 copay for day 7; \$0 copay each day for days 8+
Doctor Visits	<ul style="list-style-type: none"> <li>o Primary Care Provider</li> <li>o Specialist</li> </ul>	<p>You pay \$0 copay each visit You pay a \$50 copay each visit</p> <p>You pay a \$10 copay each visit You pay a \$50 copay each visit</p>
Preventive Care	You pay nothing	You pay nothing
Emergency Care	You pay a \$75 copay each visit	You pay a \$75 copay each visit
Urgently Needed Services	You pay a \$45 copay each visit	You pay a \$45 copay each visit

Health Partners Medicare Prime (HMO)	What You Should Know
You pay \$39.40	You must continue to pay your Medicare Part B premium.
You pay \$0	These plans do not have a deductible for medical services. There is a \$350 deductible for prescription drugs in our plans with Part D coverage (Value and Prime). Drugs in Tier 1 and Tier 2 are excluded from the deductible in the Prime plan.
\$6,700 annually	The most you pay for copays, coinsurance and other costs for medical services for the year.
You pay a \$290 copay each day for days 1-6; \$0 copay each day for days 7+	<p>Our plan covers an unlimited number of days for an inpatient hospital stay.</p> <p>All elective inpatient admissions require prior authorization. All other admissions will be reviewed for medical necessity and authorization.</p>
You pay \$0 copay each visit You pay a \$45 copay each visit	No referral is required for specialist visits. Authorization is only required for a non-participating physician specialist.
You pay nothing	Any additional preventive services approved by Medicare during the contract year will be covered. There are some items not covered at \$0 cost.
You pay a \$75 copay each visit	Copay is waived if you are admitted within 24 hours to the same facility as the Emergency Room visit.
You pay a \$45 copay each visit	

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)
<p>Diagnostic Services/Labs/ Imaging</p> <ul style="list-style-type: none"> <li>○ Lab services</li> <li>○ Medicare-covered diagnostic tests and procedures</li> <li>○ Outpatient diagnostic imaging tests (such as X-rays, ultrasound and mammography)</li> <li>○ Advanced radiology services (such as MRI, PET, CT, Nuclear Medicine)</li> <li>○ Therapeutic radiology (such as radiation treatment for cancer)</li> </ul>	<p>You pay \$0 copay each visit</p> <p>You pay \$0 copay each visit</p> <p>You pay a \$40 copay each visit</p> <p>You pay a \$200 copay each visit</p> <p>You pay 20% coinsurance each visit</p>	<p>You pay \$0 copay each visit</p> <p>You pay \$0 copay each visit</p> <p>You pay a \$35 copay</p> <p>You pay a \$275 copay each visit</p> <p>You pay 20% coinsurance each visit</p>
<p>Hearing Services</p> <ul style="list-style-type: none"> <li>○ Medicare-covered hearing exam</li> <li>○ Routine hearing exam</li> </ul>	<p>You pay a \$50 copay</p> <p>You pay \$0 copay</p>	<p>You pay a \$50 copay</p> <p>You pay \$0 copay</p>

Health Partners Medicare Prime (HMO)	What You Should Know
	<p>Prior authorization is required for certain services provided by your doctor or other network provider. Please contact the plan for more information.</p> <p>PCP or Specialist copay also applies if service is provided during an office visit.</p> <p>You pay \$0 copay each visit</p> <p>You pay \$0 copay each visit</p> <p>You pay a \$30 copay</p> <p>You pay a \$225 copay each visit</p> <p>You pay 20% coinsurance each visit</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)
Dental Services <ul style="list-style-type: none"> <li>○ Preventive (such as oral exam &amp; cleaning)</li> <li>○ Medicare-covered dental services</li> <li>○ Supplemental comprehensive dental services</li> </ul>	Not covered  You pay a \$50 copay  Not covered	Not covered  You pay a \$50 copay  Not covered
Vision Services <ul style="list-style-type: none"> <li>○ Medicare-covered vision services</li> <li>○ Medicare-covered eyewear</li> <li>○ Routine vision exam</li> <li>○ Supplemental eyewear</li> </ul>	You pay a \$50 copay  You pay \$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.  You pay \$0 copay  Not covered	You pay a \$50 copay  You pay \$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.  You pay \$0 copay  Not covered
Mental Health Services <ul style="list-style-type: none"> <li>○ Inpatient</li> <li>○ Outpatient individual and group therapy visits</li> </ul>	You pay a \$215 copay each day for days 1-7; \$0 copay each day for days 8-90  You pay a \$40 copay each visit for outpatient individual and group therapy	You pay a \$215 copay each day for days 1-7; \$0 copay each day for days 8-90  You pay a \$40 copay each visit for outpatient individual and group therapy
Skilled Nursing Facility	You pay \$0 copay each day for days 1-20; \$164.50 copay each day for days 21-100	You pay \$0 copay each day for days 1-20; \$164.50 copay each day for days 21-100

Health Partners Medicare Prime (HMO)	What You Should Know
\$0 copay for 2 oral exams/cleanings a year. One set of X-rays a year. One fluoride treatment a year.  You pay \$0 copay  \$800 a year toward supplemental comprehensive dental services (after a \$50 deductible).	Prior authorization may be required.
You pay a \$45 copay  You pay \$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.  You pay \$0 copay  \$260 plan coverage limit for eyewear every two years.	Routine vision exams are covered once a year.
You pay a \$215 copay each day for days 1-7; \$0 copay each day for days 8-90  You pay a \$40 copay each visit for outpatient individual and group therapy	Prior authorization is required.
You pay \$0 copay each day for days 1-20; \$164.50 copay each day for days 21-100	Prior authorization is required.  Our plans cover up to 100 days in a Skilled Nursing Facility.

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)
Rehabilitation Services <ul style="list-style-type: none"> <li>○ Occupational therapy, physical therapy and speech and language therapy visits</li> <li>○ Medicare-covered cardiac rehabilitation</li> <li>○ Medicare-covered pulmonary rehabilitation</li> </ul>	You pay a \$40 copay  You pay a \$50 copay  You pay a \$30 copay	You pay a \$40 copay  You pay a \$50 copay  You pay a \$30 copay
Ambulance	You pay a \$200 copay	You pay a \$200 copay
Transportation (routine)	Not covered	Not covered
Foot Care (podiatry services) <ul style="list-style-type: none"> <li>○ Medicare-covered foot care</li> <li>○ Routine foot care</li> </ul>	You pay a \$50 copay  Not covered	You pay a \$50 copay  Not covered
Medical Equipment/Supplies <ul style="list-style-type: none"> <li>○ Durable Medical Equipment (such as wheelchairs, oxygen)</li> <li>○ Prosthetics (such as braces, artificial limbs)</li> <li>○ Diabetes supplies</li> </ul>	You pay 20% of the total cost  You pay 20% of the total cost  You pay 0% to 20% of the total cost	You pay 20% of the total cost  You pay 20% of the total cost  You pay 0% to 20% of the total cost

Health Partners Medicare Prime (HMO)	What You Should Know
You pay a \$40 copay	Prior authorization is required.
You pay a \$45 copay	
You pay a \$30 copay	
You pay a \$200 copay	Authorization is required on non-emergency ambulance transportation only.
Not covered	
You pay a \$50 copay	
Not covered	
You pay 20% of the total cost	Prior authorization is required for Durable Medical Equipment costing more than \$500.
You pay 20% of the total cost	Prior authorization is required.
You pay 0% to 20% of the total cost	0% coinsurance will apply to diabetes monitoring supplies from preferred manufacturers; 20% coinsurance will apply to diabetes monitoring supplies from non-preferred manufacturers. Prior authorization is required for non-preferred manufacturers. 20% coinsurance will apply to all other Part B diabetic supplies.

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)
Wellness Programs <ul style="list-style-type: none"> <li>○ Fitness</li> <li>○ Weight Watchers®</li> </ul>	You pay \$0 for membership at network fitness centers  \$2 a visit	You pay \$0 for membership at network fitness centers  \$2 a visit
Medicare Part B Drugs	You pay \$0 or 20% of the total cost for chemotherapy drugs and other Part B drugs	You pay \$0 or 20% of the total cost for chemotherapy drugs and other Part B drugs

Health Partners Medicare Prime (HMO)	What You Should Know
You pay \$0 for membership at network fitness centers  \$2 a visit	Weight Watchers benefit covers up to 50 weeks a year.
You pay \$0 or 20% of the total cost for chemotherapy drugs and other Part B drugs	Prior authorization may be required.

	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	
<b>OUTPATIENT PRESCRIPTION DRUGS</b>			
Deductible Stage	This plan has no drug coverage	You pay \$350 per year for Part D prescription drugs	
Initial Coverage Stage (After you pay your deductible, if applicable)		<b>Standard Retail Rx 30-day supply</b>	<b>Mail Order 90-day supply</b>
Tier 1: Preferred Generic		\$2 copay	\$4 copay
Tier 2: Generic		\$20 copay	\$40 copay
Tier 3: Preferred Brand		\$47 copay	\$94 copay
Tier 4: Non-Preferred Drug		34% of the total cost	34% of the total cost
Tier 5: Specialty Tier		26% of the total cost	A long-term supply is not available for drugs in Tier 5.

Health Partners Medicare Prime (HMO)	
You pay \$350 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.	
<b>Standard Retail Rx 30-day supply</b>	<b>Mail Order 90-day supply</b>
\$7 copay	\$14 copay
\$20 copay	\$40 copay
\$47 copay	\$94 copay
35% of the total cost	35% of the total cost
26% of the total cost	A long-term supply is not available for drugs in Tier 5.

	<b>Health Partners Medicare Basic (HMO)</b>	<b>Health Partners Medicare Value (HMO)</b>	<b>Health Partners Medicare Prime (HMO)</b>
<b>Coverage Gap Stage</b> (After the total amount for the prescription drugs you have filled and refilled reaches \$3,700)		<p>When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 40% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.</p> <p>You also receive some coverage for generic drugs. You pay no more than 51% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (49%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.</p> <p>Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.</p> <p>During this stage, the plan will pay most of the cost for your drugs.</p> <ul style="list-style-type: none"> <li>• <b>Your share</b> of the cost for a covered drug will be either coinsurance or a copayment, whichever is the <i>larger</i> amount: <ul style="list-style-type: none"> <li>– <i>either</i> – coinsurance of 5% of the cost of the drug</li> <li>– <i>or</i> – \$3.30 for a generic drug or a drug that is treated like a generic and \$8.25 for all other drugs.</li> </ul> </li> </ul> <p><b>Our plan pays the rest</b> of the cost</p> <p>Your costs may vary in long term care or home infusion settings. For more information, please see the plan's Evidence of Coverage at <a href="http://www.HPPMedicare.com">www.HPPMedicare.com</a> or call us at 1-866-901-8000 (TTY 711). You can call 24 hours a day, seven days a week.</p>	<p>When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 40% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.</p> <p>You also receive some coverage for generic drugs. You pay no more than 51% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (49%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.</p> <p>Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.</p> <p>During this stage, the plan will pay most of the cost for your drugs.</p> <ul style="list-style-type: none"> <li>• <b>Your share</b> of the cost for a covered drug will be either coinsurance or a copayment, whichever is the <i>larger</i> amount: <ul style="list-style-type: none"> <li>– <i>either</i> – coinsurance of 5% of the cost of the drug</li> <li>– <i>or</i> – \$3.30 for a generic drug or a drug that is treated like a generic and \$8.25 for all other drugs.</li> </ul> </li> </ul> <p><b>Our plan pays the rest</b> of the cost</p> <p>Your costs may vary in long term care or home infusion settings. For more information, please see the plan's Evidence of Coverage at <a href="http://www.HPPMedicare.com">www.HPPMedicare.com</a> or call us at 1-866-901-8000 (TTY 711). You can call 24 hours a day, seven days a week.</p>
<b>Catastrophic Coverage Stage</b> (After your out-of-pocket costs have reached the \$4,950 limit for the calendar year)			
<b>Long-term Care Pharmacy and Out-of-network Pharmacy Coverage</b>			

Other Benefits		
	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)
Chiropractor Visits	You pay a \$20 copay	You pay a \$20 copay
Home Health Care	You pay \$0 copay	You pay \$0 copay
Hospice	You pay \$0 copay	You pay \$0 copay
Outpatient Surgery	<ul style="list-style-type: none"> <li>○ Ambulatory surgical center</li> <li>○ Outpatient hospital</li> </ul>	<p>You pay a \$180 copay You pay a \$250 copay</p> <p>You pay a \$200 copay You pay 25% of the total cost</p>

Other Benefits	
Health Partners Medicare Prime (HMO)	What You Should Know
You pay a \$20 copay	Limited to Medicare-covered chiropractic visits. Prior authorization is required.
You pay \$0 copay	Prior authorization is required
You pay \$0 copay	Prior authorization is required. Services must be provided by 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. Contact us for more details.
You pay a \$175 copay You pay a \$275 copay	Prior authorization may be required.

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Visit us at [HPPMedicare.com](http://HPPMedicare.com)

**Health Partners** Plans



Doing it right.