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2018 Summary of Benefits

**Health Partners Medicare
Basic, Value and Prime (HMO)**

Health Partners Plans 

2018 Summary of Benefits
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 medical services covered by Health Partners Medicare Basic, Health Partners Medicare Value and Health Partners Medicare Prime for the plan year January 1, 2018 – December 31, 2018.

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 the services we cover, please see the *Evidence of Coverage*. View it online at www.HPPMedicare.com or get a copy by calling Member Relations at 1-866-901-8000 (TTY 711), 24 hours a day, seven days a week.

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.

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 or by calling the plan at 1-866-901-8000 (TTY 711). You can call 24 hours a day, 7 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 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.

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. You must continue to pay your Medicare Part B premium.

H9207_HPM-414-18 Accepted 9/2017

	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
Monthly Plan Premium You must continue to pay your Medicare Part B premium.	You pay \$0.	You pay \$0.	You pay \$37.
Deductible These plans do not have a plan level 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.	You pay \$0.	You pay \$0.	You pay \$50 for comprehensive supplemental dental services.
Maximum Out-of-Pocket Responsibility <i>(does not include prescription drugs)</i> This is the most you pay for copays, coinsurance and other costs for medical services for the year.	\$6,700 annually	\$6,700 annually	\$6,700 annually

OUTPATIENT PRESCRIPTION DRUG BENEFITS (PART D)

	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)		Health Partners Medicare Prime (HMO)	
Deductible Stage	This plan has no Part D drug coverage.	You pay \$350 per year for Part D prescription drugs except for drugs listed in Tier 1 and Tier 2, which are excluded from the deductible.		You pay \$350 per year for Part D prescription drugs except for drugs listed in Tier 1 and Tier 2, which are excluded from the deductible.	
Initial Coverage Stage (after you pay your deductible, if applicable)		Standard Retail Rx 30-day supply	Mail Order 90-day supply	Standard Retail Rx 30-day supply	Mail Order 90-day supply
Tier 1: Preferred Generic		\$4 copay	\$8 copay	\$7 copay	\$14 copay
Tier 2: Generic		\$20 copay	\$40 copay	\$20 copay	\$40 copay
Tier 3: Preferred Brand		\$47 copay	\$94 copay	\$47 copay	\$94 copay
Tier 4: Non-Preferred Drug		27% of the total cost	27% of the total cost	29% of the total cost	29% of the total cost

	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)		Health Partners Medicare Prime (HMO)	
Tier 5: Specialty Tier	This plan has no Part D drug coverage.	26% of the total cost	A long-term supply is not covered for drugs in Tier 5.	26% of the total cost	A long-term supply is not covered for drugs in Tier 5.
Coverage Gap Stage (after the total amount for the prescription drugs you have filled and refilled reaches \$3,750)		When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 35% 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 move you through the coverage gap. You also receive some coverage for generic drugs. You pay no more than 44% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.		When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 35% 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 move you through the coverage gap. You also receive some coverage for generic drugs. You pay no more than 44% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (56%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.	

	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
Catastrophic Coverage Stage (after your out-of-pocket costs have reached the \$5,000 limit for the calendar year)	This plan has no Part D drug coverage.	<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"> • Your share 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"> – <i>either</i> – coinsurance of 5% of the cost of the drug – <i>or</i> – \$3.35 for a generic drug or a drug that is treated like a generic and \$8.35 for all other drugs <p>Our plan pays the rest of the cost.</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"> • Your share 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"> – <i>either</i> – coinsurance of 5% of the cost of the drug – <i>or</i> – \$3.35 for a generic drug or a drug that is treated like a generic and \$8.35 for all other drugs <p>Our plan pays the rest of the cost.</p>
Long-Term Care Pharmacy and Out-of-Network Pharmacy Coverage		<p>Your costs may vary in long-term care or home infusion settings. For more information, please see the plan's <i>Evidence of Coverage</i> at www.HPPMedicare.com or call us at 1-866-901-8000 (TTY 711). You can call 24 hours a day, seven days a week.</p>	<p>Your costs may vary in long-term care or home infusion settings. For more information, please see the plan's <i>Evidence of Coverage</i> at www.HPPMedicare.com or call us at 1-866-901-8000 (TTY 711). You can call 24 hours a day, seven days a week.</p>

MEDICAL BENEFITS (PART C)

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Inpatient Hospital Coverage</p> <p>Our plans cover up to 90 days for an inpatient hospital stay.</p> <p>Our plans also cover 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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>All elective inpatient admissions require prior authorization. All other admissions will be reviewed for medical necessity and authorization.</p>	<p>You pay a \$260 copay each day for days 1–7; \$0 copay each day for days 8–90.</p> <p>You pay a \$0 copay for each lifetime reserve day.</p> <p>Copays apply for each inpatient hospital admission/stay.</p>	<p>You pay a \$295 copay each day for days 1–6; \$180 copay for day 7; \$0 copay each day for days 8–90.</p> <p>You pay a \$0 copay for each lifetime reserve day.</p> <p>Copays apply for each inpatient hospital admission/stay.</p>	<p>You pay a \$290 copay each day for days 1–6; \$0 copay each day for days 7–90.</p> <p>You pay a \$0 copay for each lifetime reserve day.</p> <p>Copays apply for each inpatient hospital admission/stay.</p>
<p>Outpatient Hospital Services/Surgery</p> <ul style="list-style-type: none"> ○ Ambulatory surgical center ○ Outpatient hospital <p>Prior authorization may be required.</p>	<p>You pay a \$150 copay.</p> <p>You pay a \$250 copay.</p>	<p>You pay a \$200 copay.</p> <p>You pay 25% of the total cost.</p>	<p>You pay a \$175 copay.</p> <p>You pay a \$250 copay.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Doctor Visits</p> <ul style="list-style-type: none"> ○ Primary care provider ○ Specialist <p>Referral is required for specialist visits.</p>	<p>You pay a \$0 copay each visit.</p> <p>You pay a \$40 copay each visit.</p>	<p>You pay a \$10 copay each visit.</p> <p>You pay a \$50 copay each visit.</p>	<p>You pay a \$0 copay each visit.</p> <p>You pay a \$45 copay each visit.</p>
<p>Preventive Care</p> <p>Any additional preventive services approved by Medicare during the contract year will be covered. There are some services not covered at \$0 cost. Authorization is required only for certain advanced radiology tests, such as low-dose CT scans for lung cancer screening.</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>
<p>Emergency Care</p> <p>Copay is waived if you are admitted within 24 hours to the same facility as the Emergency Room visit.</p>	<p>You pay an \$80 copay each visit.</p>	<p>You pay an \$80 copay each visit.</p>	<p>You pay an \$80 copay each visit.</p>
<p>Urgently Needed Services</p>	<p>You pay a \$45 copay each visit.</p>	<p>You pay a \$45 copay each visit.</p>	<p>You pay a \$45 copay each visit.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Diagnostic Services/ Labs/Imaging</p> <ul style="list-style-type: none"> ○ Lab services ○ Medicare-covered diagnostic tests and procedures ○ Outpatient diagnostic imaging tests (such as X-rays, ultrasound and mammography) ○ Advanced radiology services (such as MRI, PET, CT and nuclear medicine) ○ Therapeutic radiology (such as radiation treatment for cancer) <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 a \$0 copay each visit.</p> <p>You pay a \$0 copay each visit.</p> <p>You pay a \$35 copay each visit.</p> <p>You pay a \$175 copay each visit.</p> <p>You pay 20% of the total cost.</p>	<p>You pay a \$0 copay each visit.</p> <p>You pay a \$0 copay each visit.</p> <p>You pay a \$35 copay each visit.</p> <p>You pay a \$275 copay each visit.</p> <p>You pay 20% of the total cost.</p>	<p>You pay a \$0 copay each visit.</p> <p>You pay a \$0 copay each visit.</p> <p>You pay a \$30 copay each visit.</p> <p>You pay a \$225 copay each visit.</p> <p>You pay 20% of the total cost.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Hearing Services</p> <ul style="list-style-type: none"> ○ Medicare-covered hearing exam ○ Routine hearing exam <p>Routine hearing exams are covered once a year.</p> <p>Hearing aids are not covered.</p>	<p>You pay a \$50 copay.</p> <p>You pay a \$0 copay.</p>	<p>You pay a \$50 copay.</p> <p>You pay a \$0 copay.</p>	<p>You pay a \$45 copay.</p> <p>You pay a \$0 copay.</p>
<p>Dental Services</p> <ul style="list-style-type: none"> ○ Preventive (such as oral exam & cleaning) ○ Medicare-covered dental services <p>Prior authorization may be required.</p> <ul style="list-style-type: none"> ○ Supplemental comprehensive dental services 	<p>Not covered</p> <p>You pay a \$50 copay.</p> <p>Not covered</p>	<p>Not covered</p> <p>You pay a \$50 copay.</p> <p>Not covered</p>	<p>You pay a \$0 copay for 2 exams and cleanings per year, 1 set of X-rays per year and 1 fluoride treatment per year.</p> <p>You pay a \$0 copay.</p> <p>The plan pays \$800 a year toward supplemental comprehensive dental services (after a \$50 deductible).</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Vision Services</p> <ul style="list-style-type: none"> ○ Medicare-covered vision services ○ Medicare-covered eyewear ○ Routine vision exam <p>Routine vision exams are covered once a year.</p> <ul style="list-style-type: none"> ○ Supplemental eyewear 	<p>You pay a \$50 copay.</p> <p>You pay a \$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.</p> <p>You pay a \$0 copay.</p> <p>Not covered</p>	<p>You pay a \$50 copay.</p> <p>You pay a \$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.</p> <p>You pay a \$0 copay.</p> <p>\$75 plan coverage limit for routine eyewear every two years</p>	<p>You pay a \$45 copay.</p> <p>You pay a \$0 copay for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.</p> <p>You pay a \$0 copay.</p> <p>\$260 plan coverage limit for routine eyewear every two years</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Mental Health Services</p> <ul style="list-style-type: none"> ○ Inpatient <p>Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies.)</p> <p>Our plans also cover 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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>Prior authorization is required.</p> <ul style="list-style-type: none"> ○ Outpatient individual and group therapy visits <p>Prior authorization is required.</p>	<p>You pay a \$215 copay each day for days 1–7; \$0 copay each day for days 8–90.</p> <p>You pay a \$0 copay for each lifetime reserve day.</p> <p>Copays apply for each inpatient hospital admission/stay.</p> <p>You pay a \$40 copay each visit for outpatient individual and group therapy.</p>	<p>You pay a \$215 copay each day for days 1–7; \$0 copay each day for days 8–90.</p> <p>You pay a \$0 copay for each lifetime reserve day.</p> <p>Copays apply for each inpatient hospital admission/stay.</p> <p>You pay a \$40 copay each visit for outpatient individual and group therapy.</p>	<p>You pay a \$215 copay each day for days 1–7; \$0 copay each day for days 8–90.</p> <p>You pay a \$0 copay for each lifetime reserve day.</p> <p>Copays apply for each inpatient hospital admission/stay.</p> <p>You pay a \$40 copay each visit for outpatient individual and group therapy.</p>
<p>Skilled Nursing Facility</p> <p>Prior authorization is required.</p> <p>Our plans cover up to 100 days in a skilled nursing facility during each benefit period.</p>	<p>You pay a \$0 copay each day for days 1–20; \$167.50 copay each day for days 21–100.</p>	<p>You pay a \$0 copay each day for days 1–20; \$167.50 copay each day for days 21–100.</p>	<p>You pay a \$0 copay each day for days 1–20; \$167.50 copay each day for days 21–100.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Physical Therapy & Other Rehabilitation Services</p> <ul style="list-style-type: none"> ○ Occupational therapy, physical therapy and speech and language therapy visits <p>Prior authorization is required.</p> <ul style="list-style-type: none"> ○ Medicare-covered cardiac rehabilitation ○ Medicare-covered pulmonary rehabilitation 	<p>You pay a \$40 copay.</p> <p>You pay a \$50 copay.</p> <p>You pay a \$30 copay.</p>	<p>You pay a \$40 copay.</p> <p>You pay a \$50 copay.</p> <p>You pay a \$30 copay.</p>	<p>You pay a \$40 copay.</p> <p>You pay a \$45 copay.</p> <p>You pay a \$30 copay.</p>
<p>Ambulance</p> <p>Authorization is required on non-emergency ambulance transportation only.</p>	<p>You pay a \$200 copay.</p>	<p>You pay a \$200 copay.</p>	<p>You pay a \$200 copay.</p>
<p>Transportation (routine)</p>	<p>Not covered</p>	<p>Not covered</p>	<p>Not covered</p>
<p>Medicare Part B Drugs</p> <p>Prior authorization may be required.</p>	<p>You pay 20% of the total cost for chemotherapy drugs and other Part B drugs.</p>	<p>You pay 20% of the total cost for chemotherapy drugs and other Part B drugs.</p>	<p>You pay 20% of the total cost for chemotherapy drugs and other Part B drugs.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Chiropractor Visits</p> <p>Limited to Medicare-covered chiropractic visits. Referral is required. Prior authorization is required.</p>	<p>You pay a \$20 copay.</p>	<p>You pay a \$20 copay.</p>	<p>You pay a \$20 copay.</p>
<p>Foot Care (podiatry services)</p> <ul style="list-style-type: none"> ○ Medicare-covered foot care ○ Routine foot care <p>Referral is required.</p>	<p>You pay a \$40 copay.</p> <p>Not covered</p>	<p>You pay a \$50 copay.</p> <p>Not covered</p>	<p>You pay a \$45 copay.</p> <p>Not covered</p>
<p>Home Health Care</p> <p>Prior authorization is required.</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>
<p>Hospice</p> <p>Prior authorization is required.</p> <p>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 the plan for more details.</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>	<p>You pay a \$0 copay.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Medical Equipment/Supplies</p> <ul style="list-style-type: none"> ○ Durable medical equipment or DME (such as wheelchairs, oxygen, etc.) <p>Prior authorization is required for DME costing more than \$500 and all rentals.</p> <ul style="list-style-type: none"> ○ Prosthetics (such as braces, artificial limbs, etc.) <p>Prior authorization is required.</p> <ul style="list-style-type: none"> ○ Diabetes supplies <p>Prior authorization is required for diabetes monitoring supplies from non-preferred manufacturers.</p>	<p>You pay 20% of the total cost.</p> <p>You pay 20% of the total cost.</p> <p>You pay 0% or 20% coinsurance</p> <p>0% coinsurance will apply to diabetes monitoring supplies from preferred manufacturers.</p> <p>20% coinsurance will apply to diabetes monitoring supplies from non-preferred manufacturers.</p> <p>20% coinsurance will apply to all other Part B diabetic supplies.</p>	<p>You pay 20% of the total cost.</p> <p>You pay 20% of the total cost.</p> <p>You pay 0% or 20% coinsurance</p> <p>0% coinsurance will apply to diabetes monitoring supplies from preferred manufacturers.</p> <p>20% coinsurance will apply to diabetes monitoring supplies from non-preferred manufacturers.</p> <p>20% coinsurance will apply to all other Part B diabetic supplies.</p>	<p>You pay 20% of the total cost.</p> <p>You pay 20% of the total cost.</p> <p>You pay 0% or 20% coinsurance</p> <p>0% coinsurance will apply to diabetes monitoring supplies from preferred manufacturers.</p> <p>20% coinsurance will apply to diabetes monitoring supplies from non-preferred manufacturers.</p> <p>20% coinsurance will apply to all other Part B diabetic supplies.</p>

Premiums and Benefits	Health Partners Medicare Basic (HMO)	Health Partners Medicare Value (HMO)	Health Partners Medicare Prime (HMO)
<p>Wellness Programs</p> <ul style="list-style-type: none"> ○ Fitness ○ Teladoc® ○ Blood pressure cuffs and scales <p>Prior authorization is required</p>	<p>The plan pays for annual membership at participating fitness centers.</p> <p>You pay \$0 for 24-hour health advice service.</p> <p>Blood pressure cuff and/or scale will be offered to specific members with congestive heart failure to assist in monitoring and controlling their disease condition.</p>	<p>The plan pays for annual membership at participating fitness centers.</p> <p>You pay \$0 for 24-hour health advice service.</p> <p>Blood pressure cuff and/or scale will be offered to specific members with congestive heart failure to assist in monitoring and controlling their disease condition.</p>	<p>The plan pays for annual membership at participating fitness centers.</p> <p>You pay \$0 for 24-hour health advice service.</p> <p>Blood pressure cuff and/or scale will be offered to specific members with congestive heart failure to assist in monitoring and controlling their disease condition.</p>

Health Partners Medicare

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Doing it right.

