Your health. Our focus.

2020 Summary of Benefits

Health Partners Medicare Prime and Simple (HMO-POS)

Health Partners Plans

2020 Summary of Benefits

Health Partners Medicare (H9207)

Health Partners Medicare Prime (HMO-POS) (plan 002)

Health Partners Medicare Simple (HMO-POS) (plan 011)

This is a summary of drug and medical services covered by Health Partners Medicare Prime and Health Partners Medicare Simple for the plan year January 1, 2020 - December 31, 2020.

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 1-877-454-8477), 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 1-877-454-8477), 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, you may pay more 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 1-877-454-8477). You can call 24 hours a day, seven days a week.

To join Health Partners Medicare Prime or Health Partners Medicare Simple, 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: Berks, Bucks, Carbon, Chester, Dauphin, Delaware, Lancaster, Lebanon, Lehigh, Northampton , Perry and Philadelphia.

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 https://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. Call 1-833-HPP-HPP3 (1-833-477-4773) (TTY 1-877-454-8477) for more information.

	Health Partners Medicare Prime	Health Partners Medicare Simple
Monthly plan premium	$35.60 You must continue to pay your Medicare Part B premium.	$0 You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible for medical services. There is a $350 deductible for prescription drugs. Drugs in Tier 1 and Tier 2 and Tier 6 are excluded from the deductible.	This plan does not have a deductible for medical services. There is a $350 deductible for prescription drugs. Drugs in Tier 1 and Tier 2 are excluded from the deductible.
Maximum out-of-pocket amount responsibility *(does not include prescription drugs)*	$6,700 annually The most you pay for copays, coinsurance and other costs for medical services for the year.	$6,700 annually The most you pay for copays, coinsurance and other costs for medical services for the year.

	Health Partners Medicare Prime		Health Partners Medicare Simple	
Outpatient Prescription Drugs (Part D)				
	Standard retail cost-sharing (in-network) (up to a 30-day supply)	**Mail order cost-sharing** (up to a 90-day supply)	**Standard retail cost-sharing** (in-network) (up to a 30-day supply)	**Mail order cost-sharing** (up to a 90-day supply)
Deductible	$350 for Tier 3, Tier 4, and Tier 5 Part D prescription drugs. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.			
Tier 1 (Preferred Generic)	$7 copayment	$14 copayment	$7 copayment	$14 copayment
Tier 2 (Generic)	$20 copayment	$40 copayment	$20 copayment	$40 copayment
Tier 3 (Preferred Brand)	$47 copayment	$94 copayment	$47 copayment	$94 copayment
Tier 4 (Non-Preferred Drug)	25% coinsurance	25% coinsurance	25% coinsurance	25% coinsurance
Tier 5 (Specialty Tier)	26% coinsurance	A long-term supply is not covered for drugs in Tier 5.	26% coinsurance	A long-term supply is not covered for drugs in Tier 5.
Tier 6 (Select Drug Tier)	$0 copayment	$0 copayment	NA	NA

	Health Partners Medicare Prime	Health Partners Medicare Simple
Outpatient Prescription Drugs (Part D)		
Coverage Gap	After your total drug costs (including what our plan has paid and what you have paid) reach $4,020, you will pay no more than 25% coinsurance for brand name and generic drugs during the coverage gap.	After your total drug costs (including what our plan has paid and what you have paid) reach $4,020, you will pay no more than 25% coinsurance for brand name and generic drugs during the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay the greater of: • 5% coinsurance, or • $3.60 copayment for generics (including brand drugs treated as generic) and a $8.95 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 $6,350, you pay the greater of: • 5% coinsurance, or • $3.60 copayment for generics (including brand drugs treated as generic) and a $8.95 copayment for all other drugs.
Long-term care pharmacy and out-of-network pharmacy coverage	Your costs may vary in long-term care or home infusion settings. For more information, please see the plan's *Evidence of Coverage* at www.HPPMedicare.com or call us at 1-866-901-8000 (TTY 1-877-454-8477). You can call 24 hours a day, seven days a week.	Your costs may vary in long-term care or home infusion settings. For more information, please see the plan's *Evidence of Coverage* at www.HPPMedicare.com or call us at 1-866-901-8000 (TTY 1-877-454-8477). You can call 24 hours a day, seven days a week.

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Inpatient hospital coverage	For each hospital admission/stay you pay: • $200 copayment each day for days 1 to 10 and • $0 copayment each day for days 11 to 90 • $0 copayment each day for days 91 to 150 (lifetime reserve days) Our plan covers up to 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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. *Prior Authorization is required*	For each hospital admission/stay you pay*: • $1,364 deductible • $0 copayment for days 1 -60 • $341 copayment per for days 61-90 • $682 copayment each day for days 91 to 150 (lifetime reserve days). Our plan covers up to 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. Once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. *Prior Authorization is required.*
Outpatient hospital coverage		
Outpatient hospital visits	$300 copayment *Prior Authorization is required.*	20% coinsurance *Prior Authorization is required*
Outpatient hospital observation services	$300 copayment	20% coinsurance
Services provided at an ambulatory surgical center	$200 copayment *Prior Authorization is required.*	20% coinsurance *Prior authorization is required.*

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Doctor visits		
Primary Care Providers	$0 copayment	$5 copayment
Specialists	$45 copayment	$50 copayment
Medicare-covered preventive care		
Glaucoma screening	$0 copayment	$0 copayment
Diabetes self-screening	$0 copayment	$0 copayment
Barium enemas	$0 copayment	$0 copayment
Digital rectal exams	$0 copayment	$0 copayment
EKG following preventive services	$0 copayment	$0 copayment
Other Medicare-covered preventive services	$0 copayment	$0 copayment
Emergency care	$90 copayment each covered visit Copayment is waived if you are admitted to a hospital within 24 hours for the same condition.	20% coinsurance for each covered visit (up to a maximum of $90 per visit). Coinsurance is waived if you are admitted to a hospital within 24 hours for the same condition.
Urgently needed services	$55 copayment each visit	20% coinsurance (up to a maximum of $65 per visit)
Diagnostic services/labs/imaging		
Diagnostic tests and procedures	$0 copayment	20% coinsurance
Lab services	$0 copayment	20% coinsurance
Advanced radiology services (such as MRI, PET, CT and nuclear medicine)	$250 copayment	20% coinsurance
Outpatient diagnostic imaging tests (such as X-rays, ultrasound and mammography)	$30 copayment	20% coinsurance

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Diagnostic services/labs/imaging (cont)		
Therapeutic radiology (such as radiation treatment for cancer)	20% coinsurance PCP or Specialist copayment also applies if service is provided during an office visit. Prior authorization is required for certain services provided by your doctor or other network provider.	20% coinsurance PCP or Specialist copayment also applies if service is provided during an office visit. Prior authorization is required for certain services provided by your doctor or other network provider.
Hearing services		
Medicare-covered hearing exam	$45 copayment	$50 copayment
Routine hearing exam	$0 copayment Limited to 1 visit every year	$0 copayment Limited to 1 visit every year
Hearing Aids	$ 0 copayment Up to $1,000 every three years	$0 copayment Up to $500 every three years
Dental services		
Preventive dental services	You pay $0 copay for 2 exams and cleanings per year, 1 set of X-rays per year and 1 fluoride treatment per year.	You pay $0 copay for 2 exams and cleanings per year, 1 set of X-rays per year and 1 fluoride treatment per year.
Comprehensive dental services	The plan pays $1,000 a year toward supplemental comprehensive dental services *Prior authorization is required.*	Not covered
Vision care		
Medicare-covered services include: • Exam to diagnose and treat diseases and conditions of the eye • Eyewear after cataract surgery Routine eye exam Supplemental eyeglasses or contact lenses	$45 copayment for Medicare-covered services $0 copayment for Medicare-covered eyewear $0 copayment for routine eye exam (limited to 1 visit every year) $0 copayment for supplemental eyewear (up to a $120 limit toward eyeglasses or contact lenses every year)	$50 copayment for Medicare-covered services $0 copayment for Medicare-covered eyewear $0 copayment for routine eye exam (limited to 1 visit every year) $0 copayment for supplemental eyewear (up to a $100 limit toward eyeglasses or contact lenses every year)

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Mental health services		
Inpatient visit	For each hospital admission/stay you pay: • $210 copayment per day for days 1 – 7: • $0 copayment for days 8 – 90: • $0 copayment per day for days 91 and beyond: (lifetime reserve days): Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). 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. *Prior Authorization is required.*	For each hospital admission/stay you pay*: • $1,364 deductible • $0 copayment for days 1 -60 • $341 copayment per day for days 61-90 • $682 copayment each day for days 91 to 150 (lifetime reserve days). Our plans cover up to 90 days for an inpatient mental health hospital stay (190-day lifetime psychiatric hospital limit applies). 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. *Prior Authorization is required*
Outpatient group therapy visit Outpatient individual therapy visit Psychiatric services	$40 copayment *Prior authorization is not required for initial consultation. Prior authorization required for subsequent visits.*	20% coinsurance *Prior authorization is not required for initial consultation. Prior authorization required for subsequent visits.*

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Skilled nursing facility	Days 1 to 20: $0 copayment per day Days 21 to 100: $172 copayment each day Our plan covers up to 100 days in a skilled nursing facility during each benefit period. *Prior Authorization is required.*	Days 1 to 20: $0 copayment per day Days 21 to 100: $170.50 copayment each day* Our plan covers up to 100 days in a skilled nursing facility during each benefit period. *Prior Authorization is required.*
Physical/occupational/speech & language therapy	$40 copayment *Prior Authorization is required.*	20% coinsurance *Prior Authorization is required*
Ambulance services Ground ambulance	$210 copayment *Prior Authorization is required for non-emergency ambulance transportation.*	20% coinsurance *Prior Authorization is required for non-emergency ambulance transportation.*
Air ambulance	20% coinsurance *Prior Authorization is required for non-emergency ambulance transportation.*	20% coinsurance *Prior Authorization is required for non-emergency ambulance transportation.*
Transportation (routine)	$0 copayment for up to 30 one-way trips to plan approved health-related facilities per year.	Not Covered
Medicare Part B prescription drugs Chemotherapy drugs	20% coinsurance *Prior Authorization is required.*	20% coinsurance *Prior Authorization is required.*
Other Part B drugs	20% coinsurance *Prior Authorization is required.*	20% coinsurance *Prior Authorization is required.*

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Podiatry services Medicare-covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Foot care for members with certain medical conditions affecting the lower limbs. Routine foot care	$45 copayment for Medicare-covered services $20 copayment for routine foot care (limited to one visit every three months)	20% coinsurance for Medicare-covered services. Routine foot care not covered.
Prosthetics/Orthotics	20% coinsurance *Prior authorization is required* for *Prosthetics/Orthotics costing more than $500.*	20% coinsurance *Prior authorization is required* for *Prosthetics/Orthotics costing more than $500.*
Diabetic supplies	0% coinsurance for diabetic supplies from preferred manufacturers 20% coinsurance for diabetic supplies from non-preferred manufacturers *Prior Authorization is required for non-preferred Diabetes Monitoring Supplies (DMS) and all other Part B diabetic supplies.*	20% coinsurance for diabetic supplies. *Prior Authorization is required.*
Fitness program	$0 copayment for up to $25 per month towards annual membership. If using a SilverSneakers facility, there will be no out of pocket costs.	Not covered

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Telemedicine Members have 24/7/365 access to credentialed providers by phone or video. This service will not replace the role of the member's PCP and is a convenient option that allows members to talk to a doctor or nurse practitioners who can diagnose, recommend treatment and prescribe medication, when appropriate, for many non-emergent medical issues, including: bronchitis/sinus problems, allergies, cold/flu symptoms, respiratory infections and ear infections.	$0 copayment	Not covered
Telemonitoring Home tele-monitoring devices will be offered to Members who have congestive heart failure (CHF) or Diabetes. Members will be provided clinical support through an application which allows chat, phone calls and video chat. In addition, scales and blood pressure cuffs may be offered to members with CHF and hypertension. The purpose of the items is to enable these specific members to monitor their blood pressure and body weight, and report to their doctor according to the doctor's direction. A doctor must recommend that a member needs these items. Limitations may apply.	$0 copayment for telemonitoring services. *Prior authorization is required.*	Not covered
Acupuncture services	$5 copayment Limited to 20 visits every year	Not covered
Annual physical exam	Not covered	Not covered
Cardiac rehabilitation services	$50 copayment	20% coinsurance

	Health Partners Medicare Prime	Health Partners Medicare Simple
Medical Benefits (Part C)		
Chiropractic services Medicare-covered services: • We only cover manual manipulation of the spine to correct subluxation.	$20 copayment *Prior Authorization is required.*	20% coinsurance *Prior Authorization is required.*
Home health care	$0 copayment *Prior Authorization is required.*	$0 copayment *Prior Authorization is required.*
Opioid treatment services	$40 copayment	20% coinsurance
Outpatient blood services	Not covered	Not covered
Over-the-counter (OTC) items	$0 copayment for up to $25 each month towards eligible OTC items. Unused portions cannot be rolled over to the next month.	Not covered
Pulmonary rehabilitation services	$30 copayment	20% coinsurance
Telehealth (by a PCP or specialist) You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth.	$0 copayment for each PCP telehealth service $45 copayment for each specialist telehealth service. *Prior authorization is required.*	Not covered
Worldwide emergency/urgent coverage	$0 copayment up to $5,000 maximum per year.	Not covered
Point-of-service option These are “out of network” benefits. You may see any provider who participates with Medicare within the United States. Contact plan for full list of services covered under this option.	20% coinsurance for covered out-of-network services	20% coinsurance for covered out-of-network services

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to Member Relations at 1-866-901-8000 (TTY 1-877-454-8477).

Understanding the Benefits

- ☐ Review the full list of benefits found in the *Evidence of Coverage* (EOC), especially for those services for which you routinely see a doctor. Visit www.HPPMedicare.com or call 1-866-901-8000 (TTY 1-877-454-8477) to view a copy of the EOC.
- ☐ Review the *Provider & Pharmacy Directory* (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor. However, the plans shown in this Summary of Benefits are point-of-service plans that allow you to obtain physician specialist and certain other services from out-of-network providers. Please contact the plan for more information.
- ☐ Review the *Provider & Pharmacy Directory* to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2021.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the *Provider & Pharmacy Directory*). However, the plans shown in this Summary of Benefits are point-of-service plans that allow you to obtain physician specialist and certain other services from out-of-network providers. Please contact the plan for more information.

Health Partners Medicare
901 Market Street, Suite 500
Philadelphia, PA 19107

1-833-HPP-HPP3 (TTY 1-877-454-8477)

HPPMedicare.com

Health Partners Plans HPP Doing it right.

H9207_HPM-220S05-1227_M