PPHP

PROVIDER PARTNERS HEALTH PLANS

Summary of Benefits

Provider Partners Pennsylvania Advantage Plan (HMO SNP) (H4093-001)

This is a summary of drug and health services covered by Provider Partners Pennsylvania Advantage Plan (HMO SNP) for the plan year: January 1, 2021 - December 31, 2021.

Provider Partners Pennsylvania Advantage Plan (HMO SNP) is a Health Maintenance Organization (HMO) Special Needs plan (SNP) with a Medicare contract. Enrollment in Provider Partners Pennsylvania Advantage Plan depends on contract renewal.

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

To join **Provider Partners Pennsylvania Advantage Plan (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. This plan is available to anyone with Medicare who meets the Skilled Nursing Facility (SNF) level of care and resides in a contracted nursing home. You must continue to pay your Medicare Part B Premium. Our service area includes the following counties in Pennsylvania: Allegheny, Armstrong, Beaver, Bucks, Butler, Chester, Delaware, Fayette, Greene, Lancaster, Lawrence, Mercer, Montgomery, Philadelphia, Washington, and Westmoreland.

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Premiums and Benefits	Provider Partners Health Plans	What You Should Know
Monthly Plan Premium	You pay $37.50	You must continue to pay your Medicare Part B premium.
Deductible	You pay $203	This is the 2021 amount and may change for 2022. Provider Partners Pennsylvania Advantage Plan (HMO SNP) will provide an updated amount as soon as they are released by Medicare.
Maximum Out-of-Pocket Responsibility *(does not include prescription drugs)*	$7,550 annually	The most you pay per year for copays, coinsurance and other costs for medical services.
Inpatient Hospital Coverage	You pay: $1,484 Deductible for each Benefit Period. Days 1-60: $0 copay per day for each benefit period. Days 61-90: $371 copay per day for each benefit period. Days 91 and beyond: $742 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs.	Our plan covers 90 days for inpatient hospital stays and 60 lifetime reserve days. These are 2021 cost-sharing amounts and may change for 2022. Provider Partners Pennsylvania Advantage Plan (HMO SNP) will provide updated rates as soon as they are released by Medicare. *Prior authorization may apply*
Outpatient Hospital Coverage	You pay 20% of the total cost for Medicare-covered services.	*Prior authorization may apply*
Ambulatory Surgery Center	You pay 20% of the total cost for Medicare-covered services.	*Prior authorization may apply*
Doctor Visits • Primary care • Specialists	You pay 20% of the total cost per visit for Medicare-covered primary care. You pay 20% of the total cost per visit for Medicare-covered specialist care.	
Preventive Care	You pay nothing.	Any additional preventive services approved by Medicare during the contract year will be covered.

Premiums and Benefits	Provider Partners Health Plans	What You Should Know
Emergency Care	You pay 20% of the total cost (up to $90 maximum) per visit.	Coinsurance is waived if you are admitted to the same hospital within 24 hours for the same condition. Emergency care is covered only within the United States.
Urgently Needed Services	You pay 20% of the total cost (up to $65 maximum) per visit.	Urgent care is covered only within the United States.
Diagnostic Services/Labs/ Imaging (Medicare-covered) • Lab Services • Diagnostic tests and procedures • Outpatient diagnostic imaging tests (such as X-rays and ultrasound) • Advanced radiology services (such as MRI, PET, CT, Nuclear Medicine) • Therapeutic radiology (such as radiation treatment for cancer)	 You pay 20% of the total cost of Medicare-covered services. You pay 20% of the total cost of Medicare-covered services. You pay 20% of the total cost of Medicare-covered services. You pay 20% of the total cost of Medicare-covered services. You pay 20% of the total cost of Medicare-covered services.	Please contact the plan's Member Services at 1-800-405-9681 (TTY 711). *Prior Authorization may apply.*
Hearing Services • Medicare-covered hearing exams • Routine hearing exam • Hearing aids	 You pay 20% of the total cost for Medicare-covered services. You pay 0% of the total cost. Our plan pays up to $1,000 every 2 years for hearing aids. The $1,000 amount applies to both ears combined.	Our plan pays for a routine hearing exam every year. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the routine hearing exam benefit.
Dental Services • Medicare-covered dental services • Preventive (such as oral exam & cleaning) • Supplemental comprehensive dental services	 You pay 20% of the total cost for Medicare-covered services. You pay a $0 copay for 1 exam and cleaning per year, 1 set of X-rays per year and 1 fluoride treatment per year. $1,500 for preventative and comprehensive dental services combined.	 Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the supplemental comprehensive and preventative dental services benefit.

Premiums/Benefits	Provider Partners Health Plans	What You Should Know
Vision Services • Medicare-covered eye exams	You pay 20% of the total cost of Medicare-covered services.	
• Medicare-covered eyewear	You pay a 20% of the total cost of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery.	
• Routine vision exam	You pay 0% of the total cost.	Our plan pays for a routine eye exam every year.
• Supplemental eyewear	$150 maximum plan coverage amount for routine eye wear every year.	Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the supplemental eyewear benefit.
Mental Health Services • Inpatient visit	You pay: $1,484 deductible for each benefit period. Days 1-60: $0 copay per day for each benefit period. Days 61-90: $371 copay per day for each benefit period. Days 91 and beyond: $742 copay per each "lifetime reserve day" after day 90 for each benefit period (up to 60 days over your lifetime). Beyond lifetime reserve days: You pay all costs.	Our plan covers up to 190 days in a lifetime for inpatient services in a psychiatric hospital. These are 2021 cost-sharing amounts and may change for 2022. Provider Partners Pennsylvania Advantage Plan (HMO SNP) will provide updated rates as soon as they are released by Medicare. *Prior authorization may apply.*
• Outpatient Individual/Group Therapy	You pay 20% of the total cost for Medicare-covered services.	*Prior authorization may apply.*
Skilled Nursing Facility	You pay: Days 1-20: $0 for each benefit period. Days 21-100: $185.50 copay per day for each benefit period. Days 101 and beyond: You pay all costs.	Our plan covers up to 100 days, per benefit period. These are 2021 cost-sharing amounts and may change for 2022. Provider Partners Pennsylvania Advantage Plan (HMO SNP) will provide updated rates as soon as they are released by Medicare. *Prior Authorization may apply.*

Premiums/Benefits	Provider Partners Health Plans	What You Should Know
Rehabilitation Services (Medicare-covered) • Occupational therapy, physical therapy and speech and language therapy visit • Cardiac rehabilitation • Pulmonary rehabilitation	 You pay 20% of the total cost for Medicare-covered services. You pay 20% of the total cost for Medicare-covered services. You pay 20% of the total cost for Medicare-covered services.	 *Prior authorization may apply.* *Prior authorization may apply.* *Prior authorization may apply.*
Ambulance (Medicare-covered ground and air transport)	You pay 20% of the total cost for each one-way Medicare-covered ambulance trip.	
Transportation (non-emergent)	You pay a $0 copay for up to 28 one-way trips every year to health-related locations via taxi, rideshare services, van, or medical transport.	Our plan covers up to 28 one-way trips for non-emergency transportation. This benefit allows members to be accompanied by a health aid, if member chooses so. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the transportation benefit.
Medicare Part B Drugs	You pay 20% of the total cost for Medicare-covered Part B drugs.	Authorizations are required for billed charges in excess of $500.
Foot Care (podiatry services) • Medicare-covered foot care • Routine foot care	 You pay 20% of the total cost for Medicare-covered services. You pay 0% of the total cost for up to 4 visits every year.	 Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the routine foot care benefit.
Medical Equipment/Supplies (Medicare-covered) • Durable Medical Equipment (such as wheelchairs, oxygen) • Prosthetics (such as braces, artificial limbs) • Diabetes supplies	 You pay 20% of the total cost for Medicare-covered services. You pay 20% of the total cost for Medicare-covered services. You pay 20% of the total cost for Medicare-covered services.	 Authorizations are required for billed charges in excess of $500. Authorizations are required for billed charges in excess of $500. Authorizations are required for billed charges in excess of $500.

Premiums/Benefits	Provider Partners Health Plans	What You Should Know
Special Supplemental Benefits for the Chronically Ill • Transportation for Non-Medical Needs	Our plan allows members to take 4 one-way trips per year to non-medical locations, like the grocery store, up to 60 miles.	This benefit will apply to members with one or more chronic conditions. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the Transportation for Non-Medical Needs benefit.
Over the Counter (OTC) Benefit	Limited to $50 allowance every quarter for specific over-the-counter drugs and other health-related products, as listed in the OTC catalog.	Any unused benefit expires at the end of each quarter and cannot be carried over to the next quarter. Call Member Services or refer to the Evidence of Coverage, Chapter 4, for more information on the over the counter benefit.

Prescription Drug Benefits	
Provider Partners Health Plans	
Deductible Stage	$445 During this stage, you pay the full cost of your drugs before our plan begins to pay its share of your drugs. You stay in this stage until you have paid $445 for your drugs.
Initial Coverage Stage (After you pay your deductible, if applicable)	You pay copays or coinsurance until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and the Plan. You may get your drugs at network retail pharmacies and mail order pharmacies.
Standard Retail / Mail Order Cost-Sharing (30-day supply)	
Tier 1: All Part D Covered Drugs	You pay 25% of the total cost of the drug
Coverage Gap Stage (After the total amount for the prescription drugs you have filled and refilled reaches $4,130)	Most Medicare drug plans have a coverage gap stage (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 $4,130. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs (plus a portion of the dispensing fee) and 25% of the plan's cost for covered generic drugs until your costs total $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Prescription Drug Benefits	
Standard Retail / Mail Order Cost-Sharing (30-day supply)	
Catastrophic Coverage Stage (After your out-of-pocket costs have reached the $6,550 limit for the calendar year)	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: • – *either* – coinsurance of 5% of the cost of the drug • –*or* – $3.70 for a generic drug or a drug that is treated like a generic and $9.20 for all other drugs. Our plan pays the rest of the cost.
Long-term Care Pharmacy and Out-of-network Pharmacy Coverage	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get a 30-day supply of drugs from an out-of-network pharmacy at the same cost as in-network pharmacy.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

For more information contact Member Services at 1-800-405-9681, or for the hearing impaired our TTY number at 711. Hours are 8:00 A.M. to 8:00 P.M., seven days a week from October 1 through March 31; 8:00 A.M. to 8:00 P.M. Monday to Friday from April 1 through September 30.

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 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.

Other Benefits		
Premiums/Benefits	**Provider Partners Health Plans**	**What You Should Know**
Chiropractor Visits (Medicare-covered)	You pay 20% of the total cost for Medicare-covered chiropractic services.	*Prior Authorization may apply.*
Home Health Care (Medicare-covered)	You pay 0% of the total cost for Medicare-covered services.	*Prior Authorization may apply.*
Home Infusion Services (Medicare-covered)	You pay 20% of the total cost for Medicare-covered home infusion services.	*Prior Authorization may apply.*

For more information, please call us toll-free at 1-800-405-9681, TTY users should call 711 or visit us at **www.pphealthplan.com.**

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

You can see our plan's provider directory, pharmacy directory, and the complete plan formulary (list of Part D prescription drugs) on our website at www.pphealthplan.com. The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

MULTI-LANGUAGE INTERPRETIVE SERVICE

English
We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-405-9681 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Español (Spanish)
Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-405-9681 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

(Chinese Mandarin) 我┌提供免┌的翻┌服┌, ┌助┌解答┌于健康或┌物保┌的任何疑 ┌。如果┌需要此翻┌服┌, ┌致┌ 1-800-405-9681 (TTY 711). 我┌的中文工作人┌很┌意┌助┌。 ┌是一┌免┌服┌。

(Chinese Cantonese) ┌對我們的健康或藥物保險可能存有疑問, ┌此我們提供免費的翻譯 服務。如需翻譯服務, 請致電 1-800-405-9681 (TTY 711)。我們講中文的人員將樂意┌┌提供幫助。這 是一項免費服務。

Tagalog (Tagalog)
Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-405-9681 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Français (French)
Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-405-9681 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

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

(German) Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-405-9681 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

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

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

(Arabic) العربية
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-405-9681 (TTY 711).هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية بمساعدتك.

(Hindi) हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-405-9681 (TTY 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

(Italian) È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-405-9681 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Português (Portugese)
Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-405-9681 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

Kreyòl Ayisyen (French Creole)
Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-405-9681 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polski (Polish)
Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-405-9681 (TTY 711). Ta usługa jest bezpłatna.

(Japanese) 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには 1-800-405-9681 (TTY 711). 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。

PPHP
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