2016 SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

Horizon Medicare Blue (PPO)

Horizon Blue Cross Blue Shield of New Jersey

Y0090_12050SB-PPO_2016 Accepted

SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

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 **Horizon Medicare Blue (PPO)**).

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Horizon Medicare Blue (PPO)** covers 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 **Horizon Medicare Blue (PPO)**
- 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 (888) 765-7142 (TTY/TDD #: 711).

Esta información puede estar disponible en un formato distinto, incluido el idioma español, letra grande y cinta de audio. Llame al Departamento de Servicios al Miembro al número indicado arriba si necesita información sobre el Plan en otro formato o idioma.

THINGS TO KNOW ABOUT **HORIZON MEDICARE BLUE (PPO)**

HOURS OF OPERATION

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

HORIZON MEDICARE BLUE (PPO) PHONE NUMBERS AND WEBSITE

- If you are a member of this plan, call toll-free (800) 365-2223 (TTY/TDD #: 711).
- If you are not a member of this plan, call toll-free (888) 328-4542 (TTY/TDD #: 711).
- Our website: http://www.horizonblue.com/medicare.

WHO CAN JOIN?

To join **Horizon Medicare Blue (PPO)**, 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 county in New Jersey: Sussex.

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Horizon Medicare Blue (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

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

You can see our plan's provider directory at our website (http://directory.horizonblue.com).

You can see our plan's pharmacy directory at our website (http://www.horizonblue.com/ma-pharmacy-search).

Or, call us and we will send you a copy of the provider and pharmacy directories.

SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

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.

We cover Part D drugs. In addition, we 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, http://www.horizonblue.com/ma-drug-search.
- Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

The amount you pay for drugs depends on the drug you are taking 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.

SECTION II – SUMMARY OF BENEFITS

Horizon Medicare Blue (PPO)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

1 How much is the monthly premium?

$155.60 per month. In addition, you must keep paying your Medicare Part B premium.

2 How much is the deductible?

This plan has deductibles for some hospital and medical services, and Part D prescription drugs.

$900 per year for out-of-network services.

$360 per year for Part D prescription drugs.

3 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.
- $6,200 for services you receive from out-of-network providers.
- $10,000 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count towards this limit.

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.

4 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.

COVERED MEDICAL AND HOSPITAL BENEFITS

NOTE: • SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.
• SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.

OUTPATIENT CARE AND SERVICES.

5 Acupuncture

Not covered

6 Ambulance[1]

- In-network: $250 copay
- Out-of-network: 35% of the cost

7 Chiropractic Care

Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position):

- In-network: $20 copay
- Out-of-network: 35% of the cost

8 Dental Services

Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):

- In-network: $0 copay
- Out-of-network: 35% of the cost

9 Diabetes Supplies and Services[1]

Diabetes monitoring supplies:

- In-network: You pay nothing
- Out-of-network: 35% of the cost

Diabetes self-management training:

- In-network: You pay nothing
- Out-of-network: 35% of the cost

Therapeutic shoes or inserts:

- In-network: You pay nothing
- Out-of-network: 35% of the cost

10 Diagnostic Tests, Lab and Radiology Services, and X-Rays

(Costs for these services may vary based on place of service) [1, 2]

Diagnostic radiology services (such as MRIs, CT scans):

- In-network: $35 copay or 20% of the cost, depending on the service
- Out-of-network: 35% of the cost

Diagnostic tests and procedures:

- In-network: $35 copay or 20% of the cost, depending on the service
- Out-of-network: 35% of the cost

Diagnostic Tests, Lab and Radiology Services, and X-Rays

(Costs for these services may vary based on place of service) [1,2]

Lab services:

- In-network: 0-20% of the cost, depending on the service
- Out-of-network: 35% of the cost

Outpatient x-rays:

- In-network: $35 copay or 20% of the cost, depending on the service
- Out-of-network: 35% of the cost

Therapeutic radiology services (such as radiation treatment for cancer):

- In-network: $60 copay or 20% of the cost, depending on the service
- Out-of-network: 35% of the cost

20% coinsurance for outpatient hospital services

$60 copayment for radiation therapy in the office or freestanding facility

$35 for all other services (except lab services) in an office or freestanding facility

$0 copayment for lab services at a participating laboratory

11 Doctor's Office Visits

Primary care physician visit:

- In-network: $15 copay
- Out-of-network: 35% of the cost

Specialist visit:

- In-network: $35 copay
- Out-of-network: 35% of the cost

12 Durable Medical Equipment *(wheelchairs, oxygen, etc.)* [1]

- In-network: 20% of the cost
- Out-of-network: 35% of the cost

13 Emergency Care

$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.

Covered worldwide

14 Foot Care *(podiatry services)*

Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions:

- In-network: $35 copay
- Out-of-network: 35% of the cost

15 Hearing Services

Exam to diagnose and treat hearing and balance issues:

- In-network: $35 copay
- Out-of-network: 35% of the cost

16 Home Health Care[1]

- In-network: You pay nothing
- Out-of-network: 35% of the cost

17 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.

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.

- In-network:
  - $150 copay per day for days 1 through 10
  - You pay nothing per day for days 11 through 90
  - Out-of-network: 35% of the cost per stay

Outpatient group therapy visit:

- In-network: $35 copay
- Out-of-network: 35% of the cost

Outpatient individual therapy visit:

- In-network: $35 copay
- Out-of-network: 35% of the cost

Covers inpatient substance abuse

The cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times.

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18 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):
- In-network: $35 copay
- Out-of-network: 35% of the cost

Occupational therapy visit:
- In-network: $35 copay
- Out-of-network: 35% of the cost

Physical therapy and speech and language therapy visit:
- In-network: $35 copay
- Out-of-network: 35% of the cost

19 Outpatient Substance Abuse[1]

Group therapy visit:
- In-network: $35 copay
- Out-of-network: 35% of the cost

Individual therapy visit:
- In-network: $35 copay
- Out-of-network: 35% of the cost

20 Outpatient Surgery[1]

Ambulatory surgical center:
- In-network: $75 copay
- Out-of-network: 35% of the cost

Outpatient hospital:
- In-network: 20% of the cost
- Out-of-network: 35% of the cost

21 Over-the-Counter Items

Not covered

22 Prosthetic Devices *(braces, artificial limbs, etc.)*[1]

Prosthetic devices:
- In-network: 20% of the cost
- Out-of-network: 35% of the cost

Related medical supplies:
- In-network: 20% of the cost
- Out-of-network: 35% of the cost

23 Renal Dialysis

- In-network: 20% of the cost
- Out-of-network: 35% of the cost

20% coinsurance for dialysis services at a Medicare-certified dialysis facility when temporarily outside the plan's "service area." Otherwise, 35% coinsurance applies.

24 Transportation

Not covered

25 Urgently Needed Services

$25-35 copay, depending on the service

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.

$25 copayment for in-network urgent care center
$35 copayment for a physician's office or other setting

$75 copayment for worldwide coverage

26 Vision Services

Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening):

- In-network: $0-$35 copay
- Out-of-network: 35% of the cost

Routine eye exam (for up to 1 every year):

- In-network: $0 copay
- Out-of-network: 35% of the cost

Contact lenses:

- In-network: $0 copay
- Out-of-network: $0 copay

Eyeglasses (frames and lenses):

- In-network: $0 copay
- Out-of-network: $0 copay

Eyeglass frames:

- In-network: $0 copay
- Out-of-network: $0 copay

Eyeglass lenses:

- In-network: $0 copay
- Out-of-network: $0 copay

Vision Services

Eyeglasses or contact lenses after cataract surgery:

- In-network: $0 copay
- Out-of-network: 35% of the cost

$0 copay: glaucoma screening/annual diabetic retinal exam

$35 copay: diagnostic exam in a specialist office

This benefit covers $100 for the purchase of eyewear every 2 years for eyeglasses/contact lenses not associated with cataract surgery. Member is responsible for payment beyond $100 coverage limit.

27 Preventive Care

- In-network: You pay nothing
- Out-of-network: 35% of the cost

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.

28 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.

INPATIENT CARE

29 Inpatient Hospital Care[1]

Our plan covers an unlimited number of days for an inpatient hospital stay.

- In-network:
  - $150 copay per day for days 1 through 10
  - You pay nothing per day for days 11 through 90
  - You pay nothing per day for days 91 and beyond
- Out-of-network:
  - 35% of the cost per stay

  The cost-sharing described above applies each time you are admitted to the hospital, even if you are admitted multiple times.

30 Inpatient Mental Health Care

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

31 Skilled Nursing Facility (SNF)[1]

Our plan covers up to 100 days in a SNF.

- In-network:
  - You pay nothing per day for days 1 through 20
  - $125 copay per day for days 21 through 100
- Out-of-network:
  - 35% of the cost per stay

  You are covered up to 100 days per benefit period. A new benefit period begins each time you are not readmitted to a SNF for 60 consecutive days since your last discharge. Each benefit period begins with the Day 1 cost-share listed above. There is no annual limit to the number of benefit periods.

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PRESCRIPTION DRUG BENEFITS

32 How much do I pay?

For Part B drugs such as chemotherapy drugs[1]:

- In-network: 20% of the cost
- Out-of-network: 35% of the cost

Other Part B drugs[1]:

- In-network: 20% of the cost
- Out-of-network: 35% of the cost

33 Initial Coverage

After you pay your yearly deductible, you pay 25% of the cost for all drugs covered by this plan 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.

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.

34 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.

35 Catastrophic Coverage

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.

MULTI-LANGUAGE INSERT
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 1-888-328-4542. 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 omedicamentos. Para hablar con un intérprete, por favor llame al 1-888-328-4542. 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 1-888-328-4542。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 1-888-328-4542。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 1-888-328-4542. 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 1-888-328-4542. 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 thuốcmen. Nếu quí vị cần thông dịch viên xin gọi 1–888–328–4542 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 1-888-328-4542. 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 1-888-328-4542 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 1–888–328–4542. Вам окажет помощь сотрудник, который говорит по–русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديناً. للحصول على مترجم فوري، يرجى الاتصال بنا على 1-888-328-4542. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

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 1-888-328-4542 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 1-888-328-4542. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: 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 1-888-328-4542. 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 1-888-328-4542. 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 1–888–328–4542. 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、1-888-328-4542 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。

Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) and Horizon Healthcare of New Jersey, Inc. (HHNJ) have contracts with Medicare for HMO, PPO and PDP plans. Enrollment in Horizon BCBSNJ Medicare products depends on contract renewal. Products are provided by HHNJ and Horizon BCBSNJ, both of which are independent licensees of the Blue Cross and Blue Shield Association. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies.

Horizon® 

Horizon Blue Cross Blue Shield of New Jersey