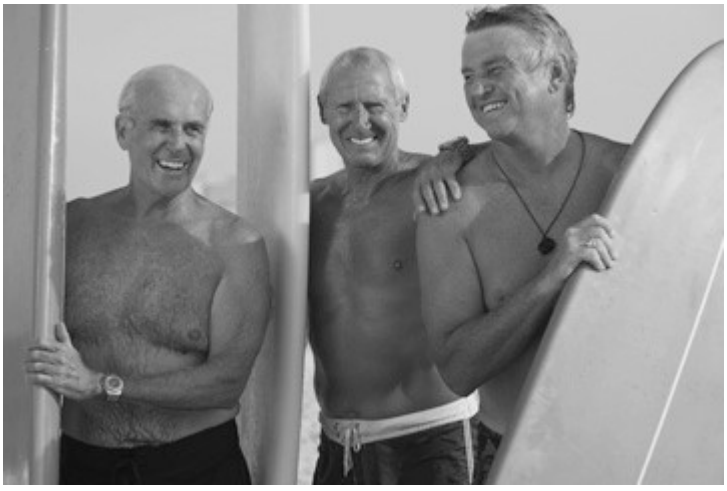
2016 Medicare Advantage Summary of Benefits

HNE Premier 3 (HMO-POS)



January 1, 2016 - December 31, 2016

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SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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 **HNE Premier 3 (HMO-POS)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **HNE Premier 3 (HMO-POS)** 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 **HNE Premier 3 (HMO-POS)**
- 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 877.443.3314 (TTY/TDD 800.439.2370).

Things to Know About HNE Premier 3 (HMO-POS)

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.

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

HNE Premier 3 (HMO-POS) Phone Numbers and Website

- If you are a member of this plan, call toll-free 877.443.3314 (TTY/TDD 800.439.2370).
- If you are not a member of this plan, call toll-free 877.443.3314 (TTY/TDD 800.439.2370).
- Our website: http://www.hne.com/medicare.

Who can join?

To join **HNE Premier 3 (HMO-POS)**, 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 Connecticut: Hartford and Tolland.

Which doctors, hospitals, and pharmacies can I use?

HNE Premier 3 (HMO-POS) has a network of doctors, hospitals, and other providers. For some services you can 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 and pharmacy directory at our website (http://www.hne.com/medicare).

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

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 including 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.hne.com/medicare.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of four "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact HNE Medicare Advantage Plans for details.

SECTION II - SUMMARY OF BENEFITS

HNE Premier 3 (HMO-POS)

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	$65 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
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. • $6,700 for services you receive from any provider. Your limit for services received from in-network providers will count toward 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.
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.

HNE Medicare Advantage is an HMO plan with a Medicare contract. Enrollment in HNE Medicare Advantage depends on contract renewal.

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	
Acupuncture	Not covered
Ambulance[1]	• In-network: $300 copay • Out-of-network: $300 copay Ambulance transportation limited to Medicare covered medically necessary ambulance services. Chair Vans are not covered.
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: $20 copay

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Dental Services[1,2]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth):
	• In-network: $45-450 copay, depending on the service
	• Out-of-network: 20% of the cost
	
	Preventive dental services:
	• Cleaning:
	  o In-network: You pay nothing
	  o Out-of-network: You pay nothing
	• Dental x-ray(s):
	  o In-network: You pay nothing
	  o Out-of-network: You pay nothing
	• Fluoride treatment:
	  o In-network: You pay nothing
	  o Out-of-network: You pay nothing
	• Oral exam:
	  o In-network: You pay nothing
	  o Out-of-network: You pay nothing
	
	Our plan pays up to $150 every year for most dental services from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.
	
	Please Note: Member must pay out of pocket for dental services and submit paid receipts to receive reimbursement for the services listed above. Other dental services are eligible for reimbursement. See the HNE allowance reimbursement form for more details.

Diabetes Supplies and Services[1]	Diabetes monitoring supplies: • In-network: You pay nothing • Out-of-network: You pay nothing Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: You pay nothing • Out-of-network: You pay nothing Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies.

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Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may be different if received in an outpatient surgery setting)*[1]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $0-300 copay, depending on the service • Out-of-network: 20% of the cost Diagnostic tests and procedures: • In-network: $25 copay • Out-of-network: 10% of the cost Lab services: • In-network: $25 copay • Out-of-network: 10% of the cost Outpatient x-rays: • In-network: $25 copay • Out-of-network: 10% of the cost Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: 10% of the cost Diagnostic imaging (CT Scans, MRIs, MRAs, PET Scans, sleep studies, nuclear cardiology)[1]: • In-network: $300 copay • Out-of-network: 20% of the cost
Doctor's Office Visits	Primary care physician visit: • In-network: $35 copay • Out-of-network: 20% of the cost Specialist visit: • In-network: $45 copay • Out-of-network: 20% of the cost No referral required for network doctors, specialists, and hospitals.
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	• In-network: 20% of the cost • Out-of-network: 20% of the cost
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. Worldwide coverage.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $45 copay • Out-of-network: 20% of the cost

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Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $45 copay • Out-of-network: 20% of the cost Routine hearing exam: • In-network: $45 copay. You are covered for up to 1 every year. • Out-of-network: 20% of the cost. There may be a limit to how often these services are covered.
Home Health Care[1]	• In-network: You pay nothing • Out-of-network: You pay nothing
Mental Health Care	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. The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. 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: o $300 copay per day for days 1 through 5 o You pay nothing per day for days 6 through 90 • Out-of-network: o 20% of the cost per stay Outpatient group therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost Outpatient individual therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost Our plan covers psychological testing and neuropsychological testing[1]: • In-network: $40 copay • Out-of-network: 20% of the cost Our plan covers partial hospitalization[1]: $0 copay. Prior authorization is required for out-of-network inpatient mental

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	health care.[1] The provider may be willing to contact us for you to obtain prior authorization. Even if your provider helps you, you should still call Member Services to confirm approval before receiving services.
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: $10 copay • Out-of-network: $10 copay Occupational therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost
Outpatient Substance Abuse	Group therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost Individual therapy visit: • In-network: $40 copay • Out-of-network: 20% of the cost
Outpatient Surgery[1]	Ambulatory surgical center: • In-network: $450 copay • Out-of-network: 20% of the cost Outpatient hospital: • In-network: $0-45 copay, depending on the service • Out-of-network: 20% of the cost The copayment range for Outpatient Hospital Services describes the varying cost share based on the services provided. The minimum copayment applies to lab and diagnostic tests, and services related to the monitoring of Coumadin treatment or Chemotherapy services. The maximum copayment applies to all other outpatient clinic services.
Over-the-Counter Items	Please visit our website to see our list of covered over-the-counter items.
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: You pay nothing • Out-of-network: 20% of the cost

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Renal Dialysis	• In-network: You pay nothing • Out-of-network: You pay nothing
Transportation	Not covered
Urgently Needed Care	$50 copay Worldwide coverage.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-45 copay, depending on the service • Out-of-network: 0-20% of the cost, depending on the service Routine eye exam: • In-network: You pay nothing. You are covered for up to 1 visit(s) every year. • Out-of-network: 0-20% of the cost, depending on the service. There may be a limit to how often these services are covered. Contact lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses): • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglass frames: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglass lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every two years for eyewear from an in-network provider. There is a limit to how much our plan will pay from an out-of-network provider.

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Preventive Care	• In-network: You pay nothing • Out-of-network: You pay nothing 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.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit[1]: $0 copay.
INPATIENT CARE	
Inpatient Hospital Care	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay.

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	• In-network:
	  o $300 copay per day for days 1 through 5
	  o You pay nothing per day for days 6 through 90
	  o You pay nothing per day for days 91 and beyond
	• Out-of-network:
	  o 20% of the cost per stay
	Prior authorization is required for out-of-network inpatient hospital care.[1] The provider may be willing to contact us for you to obtain prior authorization. Even if your provider helps you, you should still call Member Services to confirm approval before receiving services.

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

Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF.
	• In-network:
	  o You pay nothing per day for days 1 through 20
	  o $160 copay per day for days 21 through 50
	  o You pay nothing per day for days 51 through 100
	• Out-of-network:
	  o 20% of the cost per stay
	No prior hospital stay is required.

PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: You pay nothing • Out-of-network: 0-15% of the cost, depending on the drug Other Part B drugs[1]: • In-network: 15% of the cost • Out-of-network: 0-15% of the cost, depending on the drug The plan may require you to try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization for some drugs. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you pay the actual cost, not the higher cost-sharing amount.

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Initial Coverage

You pay the following 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.

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Generic)	$10 copay	$20 copay	$30 copay
Tier 2 (Preferred Brand)	$45 copay	$90 copay	$135 copay
Tier 3 (Non-Preferred Brand)	$90 copay	$180 copay	$270 copay
Tier 4 (Specialty Tier)	33% of the cost	Not Offered	Not Offered

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Generic)	$20 copay
Tier 2 (Preferred Brand)	$90 copay
Tier 3 (Non-Preferred Brand)	$270 copay

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You pay $0 the first time you fill a prescription for certain drugs. These drugs will be listed as "free first fill" on the website, formulary, printed materials, and on the Medicare Prescription Drug Plan Finder on Medicare.gov. If you request and the plan approves a formulary exception, you will pay Tier 3: Non-Preferred Brand cost sharing.

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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.
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.