



Network Platinum Medicare Advantage Plans H5215

2012 SUMMARY OF BENEFITS

**Introduction to the Summary of Benefits Report
for NETWORK PLATINUM MEDICARE ADVANTAGE (PPO) Plans
January 1, 2012 - December 31, 2012
EAST CENTRAL WISCONSIN**

Thank you for your interest in Network PlatinumPlus (PPO), Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO). Our plans are offered by NETWORK HEALTH INSURANCE CORPORATION/Network Platinum Medicare Advantage Plans, a Medicare Advantage Preferred Provider Organization (PPO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Network Health Insurance Corporation and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Network Platinum Medicare Advantage (PPO) Plans. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program. You may be able to join or leave a plan only at certain times. Please call Network Health Insurance Corporation at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS

You can compare Network Platinum Medicare Advantage (PPO) Plans and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE ARE NETWORK PLATINUM MEDICARE ADVANTAGE (PPO) Plans AVAILABLE?

The service area for these plans includes: Brown, Calumet, Dodge, Fond du Lac, Green Lake, Manitowoc, Marquette, Outagamie, Portage, Shawano, Sheboygan, Waupaca, Waushara, and Winnebago Counties, WI. You must live in one of these areas to join a plan.

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WHO IS ELIGIBLE TO JOIN NETWORK PLATINUM MEDICARE ADVANTAGE (PPO) Plans?

You can join a Network Platinum Medicare Advantage (PPO) Plan if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in a Network Platinum Medicare Advantage (PPO) Plan unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Network Platinum Medicare Advantage (PPO) Plans have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current provider directory. For an updated list, visit us at http://www.nppdrugplans.com/provider_information/members.php. Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at <http://www.nppdrugplans.com>. Our customer service number is listed at the end of this introduction.

Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO) have a list of preferred pharmacies. At these pharmacies, you may get your drugs at a lower co-pay or co-insurance. You may go to a non-preferred pharmacy, but you may have to pay more for your prescription drugs.

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DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Network PlatinumPlus (PPO), Network PlatinumPremier (PPO) Plans do cover Medicare Part B prescription drugs. Network PlatinumPlus (PPO), Network PlatinumPremier (PPO) Plans do NOT cover Medicare Part D prescription drugs.

Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO) do cover Medicare Part B prescription drugs AND Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO) Plans use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at http://www.nppdrugplans.com/find_your_prescriptions/.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- * 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week; and see <http://www.medicare.gov> 'Programs for People with Limited Income and Resources' in the publication Medicare & You.
- * The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- * Your State Medicaid Office.

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WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with the Medicare Advantage Plan Program. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Network Platinum Medicare Advantage (PPO) Plan, you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO) Plans you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a

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statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier Pharmacy (PPO), and Network PlatinumSelect (PPO) Plans for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Network Platinum Medicare Advantage (PPO) Plans for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

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- Inhalation and Infusion Drugs administered through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on <http://www.medicare.gov> and select "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call Network Health Insurance Corporation for more information about Network Platinum Medicare Advantage (PPO) Plans.

Visit us at <http://www.nppdrugplans.com> or, call us:

Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,
8:00 a.m. - 8:00 p.m. Central

Current members should call toll-free (800)-378-5234.
(TTY/TDD (800)-947-3529)

Prospective members should call toll-free (800)-983-7587.
(TTY/TDD (800)-947-3529)

Current members should call locally (920)-720-1345.
(TTY/TDD (800)-947-3529)

Prospective members should call locally (920)-720-1280.
(TTY/TDD (800)-947-3529)

For more information about Medicare, please call Medicare at
1-800-MEDICARE (1-800-633-4227).

TTY users should call
1-877-486-2048.

You can call 24 hours a day, 7 days a week.
Or, visit <http://www.medicare.gov> on the web.

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This document may be available in other formats such as Braille, large print or other alternate formats. This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

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Summary of Benefits Report

Network
Platinum*Plus*(PPO)

Network
Platinum*Plus*
Pharmacy (PPO)

Network
Platinum*Premier* (PPO)

Network
Platinum*Premier*
Pharmacy (PPO)

IMPORTANT INFORMATION

<p>1 - Premium and Other Important Information</p>	<p>In 2011 the monthly Part B Premium was \$96.40 and may change for 2012 and the annual Part B deductible amount was \$162 and may change for 2012.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be</p>
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Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>General \$36 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be</p>	<p>General \$74 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be</p>	<p>General \$77 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be</p>	<p>General \$135 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over \$85,000 for singles, \$170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> <p>Some physicians, providers and suppliers that are out of a plan's network (i.e., out-of-network) accept "assignment" from Medicare and will only charge up to a Medicare-approved amount. If you choose to see an out-of-network physician who does NOT accept Medicare "assignment," your coinsurance can be</p>
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Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
1 - Premium and Other Important Information <i>continued</i>		<p>based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on http://www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.</p> <p>To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit http://www.medicare.gov/physician or http://www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.</p>	

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on http://www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.</p>	<p>based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on http://www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.</p>	<p>based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on http://www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.</p>	<p>based on the Medicare-approved amount plus an additional amount up to a higher Medicare "limiting charge." If you are a member of a plan that charges a copay for out-of-network physician services, the higher Medicare "limiting charge" does not apply. See the publications Medicare & You or Your Medicare Benefits available on http://www.medicare.gov for a full listing of benefits under Original Medicare, as well as for explanations of the rules related to "assignment" and "limiting charges" that apply by benefit type.</p>
<p>To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit http://www.medicare.gov/physician or http://www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.</p>	<p>To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit http://www.medicare.gov/physician or http://www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.</p>	<p>To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit http://www.medicare.gov/physician or http://www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.</p>	<p>To find out if physicians and DME suppliers accept assignment or participate in Medicare, visit http://www.medicare.gov/physician or http://www.medicare.gov/supplier. You can also call 1-800-MEDICARE, or ask your physician, provider, or supplier if they accept assignment.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>1 - Premium and Other Important Information <i>continued</i></p>		<p>In-Network \$2,900 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$2,900 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>
<p>2 - Doctor and Hospital Choice</p> <p>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>

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Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>In-Network \$2,700 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$2,700 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>	<p>In-Network \$2,700 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$2,700 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>	<p>In-Network \$2,000 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$2,000 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>	<p>In-Network \$2,000 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p> <p>In and Out-of-Network \$2,000 out-of-pocket limit for Medicare-covered services and select Non-Medicare Supplemental Services. Contact plan for details regarding Non-Medicare Supplemental Services covered under this limit.</p>
<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>In and Out-of-Network You can go to doctors, specialists, and hospitals in or out of the network. It will cost more to get out of network benefits.</p> <p>Out of Service Area Plan covers you when you travel in the U.S.</p>

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Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

SUMMARY OF BENEFITS
INPATIENT CARE

3 - Inpatient Hospital Care

(includes Substance Abuse and Rehabilitation Services)

In 2011 the amounts for each benefit period were:
Days 1 - 60: \$1132 deductible
Days 61 - 90: \$283 per day
Days 91 - 150: \$566 per lifetime reserve day
These amounts may change for 2012.

Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.
Lifetime reserve days can only be used once.

A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

In-Network
No limit to the number of days covered by the plan each hospital stay.

For Medicare-covered hospital stays:
Days 1-10: \$175 copay per day
Days 11-90: \$0 copay per day
\$0 copay for each additional hospital day.

Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.

Out-of-Network
For hospital stays:
Days 1-10: \$215 copay per day
Days 11 and beyond: \$0 copay per day

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<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 10: \$0 copay per day</p> <p>Days 11 - 20: \$50 copay per day</p> <p>Days 21 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$100 copay per day</p> <p>Days 8 and beyond: \$0 copay per day</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 10: \$0 copay per day</p> <p>Days 11 - 20: \$50 copay per day</p> <p>Days 21 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$100 copay per day</p> <p>Days 8 and beyond: \$0 copay per day</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>\$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$100 copay per day</p> <p>Days 8 and beyond: \$0 copay per day</p>	<p>In-Network No limit to the number of days covered by the plan each hospital stay.</p> <p>For Medicare-covered hospital stays:</p> <p>\$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$100 copay per day</p> <p>Days 8 and beyond: \$0 copay per day</p>

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<p>4 - Inpatient Mental Health Care</p>	<p>In 2011 the amounts for each benefit period were: Days 1 - 60: \$1132 deductible Days 61 - 90: \$283 per day Days 91 - 150: \$566 per lifetime reserve day These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 10: \$175 copay per day Days 11 - 90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <p>Days 1 - 7: \$0 copay per day Days 8 - 60: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 10: \$300 copay per day Days 11 - 190: \$0 copay per day</p>
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Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 10: \$0 copay per day Days 11 - 20: \$50 copay per day Days 21 - 90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <p>Days 1 - 60: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$150 copay per day Days 8 - 190: \$0 copay per day</p>	<p>In-Network You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>For Medicare-covered hospital stays:</p> <p>Days 1 - 10: \$0 copay per day Days 11 - 20: \$50 copay per day Days 21 - 90: \$0 copay per day</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day:</p> <p>Days 1 - 60: \$0 copay per day</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$150 copay per day Days 8 - 190: \$0 copay per day</p>	<p>In-Network \$0 Copay</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$150 copay per day Days 8 - 190: \$0 copay per day</p>	<p>In-Network \$0 Copay</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays:</p> <p>Days 1 - 7: \$150 copay per day Days 8 - 190: \$0 copay per day</p>

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<p>5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$141.50 per day These amounts may change for 2012.</p> <p>100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period 3-day prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1 - 100: \$75 copay per day</p> <p>Out-of-Network For each SNF stay: Days 1 - 100: \$100 copay per SNF day</p> <p><i>See page <71 >for additional information about Skilled Nursing Facility (SNF).</i></p>
<p>6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered home health visit</p> <p>Out-of-Network 30% of the cost for home health visits</p>
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>

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<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>3-day prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1 - 100: \$50 copay per day</p> <p>Out-of-Network For each SNF stay: Days 1 - 100: \$100 copay per SNF day</p> <p><i>See page <71 >for additional information about Skilled Nursing Facility (SNF).</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>3-day prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1 - 100: \$50 copay per day</p> <p>Out-of-Network For each SNF stay: Days 1 - 100: \$100 copay per SNF day</p> <p><i>See page <71 >for additional information about Skilled Nursing Facility (SNF).</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>3-day prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1 - 100: \$35 copay per day</p> <p>Out-of-Network For each SNF stay: Days 1 - 100: \$100 copay per SNF day</p> <p><i>See page <71 >for additional information about Skilled Nursing Facility (SNF).</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network Plan covers up to 100 days each benefit period</p> <p>3-day prior hospital stay is required.</p> <p>For Medicare-covered SNF stays: Days 1 - 100: \$35 copay per day</p> <p>Out-of-Network For each SNF stay: Days 1 - 100: \$100 copay per SNF day</p> <p><i>See page <71 >for additional information about Skilled Nursing Facility (SNF).</i></p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network \$40 copay for home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network \$40 copay for home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network \$40 copay for home health visits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits</p> <p>Out-of-Network \$40 copay for home health visits</p>
<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>	<p>General You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice.</p>

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OUTPATIENT CARE		
<p>8 - Doctor Office Visits</p>	<p>20% coinsurance</p>	<p>In-Network \$15 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$20 copay for each primary care doctor visit</p> <p>\$35 copay for each specialist visit</p>
<p>9 - Chiropractic Services</p>	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$45 copay for chiropractic benefits.</p>

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Platinum*Plus*(PPO)

Network
Platinum*Plus*
Pharmacy (PPO)

Network
Platinum*Premier* (PPO)

Network
Platinum*Premier*
Pharmacy (PPO)

<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$10 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$20 copay for each primary care doctor visit</p> <p>\$35 copay for each specialist visit</p>	<p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$10 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$25 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$20 copay for each primary care doctor visit</p> <p>\$35 copay for each specialist visit</p>	<p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$20 copay for each primary care doctor visit</p> <p>\$25 copay for each specialist visit</p>	<p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for each in-area, network urgent care Medicare-covered visit</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$20 copay for each primary care doctor visit</p> <p>\$25 copay for each specialist visit</p>
<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$45 copay for chiropractic benefits.</p>	<p>In-Network \$20 copay for each Medicare-covered visit</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$45 copay for chiropractic benefits.</p>	<p>In-Network \$15 copay for each Medicare-covered visit</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$35 copay for chiropractic benefits.</p>	<p>In-Network \$15 copay for each Medicare-covered visit</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$35 copay for chiropractic benefits.</p>

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<p>10 - Podiatry Services</p>	<p>Supplemental routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$30 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$35 copay for podiatry benefits.</p>
<p>11 - Outpatient Mental Health Care</p>	<p>40% coinsurance for most outpatient mental health services</p> <p>Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual therapy visit</p> <p>\$30 copay for each Medicare-covered group therapy visit</p> <p>\$30 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$30 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$25 for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network \$45 copay for Mental Health benefits with a psychiatrist</p>

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<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$35 copay for podiatry benefits.</p>	<p>In-Network \$25 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$35 copay for podiatry benefits.</p>	<p>In-Network \$15 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$25 copay for podiatry benefits.</p>	<p>In-Network \$15 copay for each Medicare-covered visit</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$25 copay for podiatry benefits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$10 for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network \$45 copay for Mental Health benefits with a psychiatrist</p> <p>\$45 copay for Mental Health benefits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for each Medicare-covered individual therapy visit</p> <p>\$25 copay for each Medicare-covered group therapy visit</p> <p>\$25 copay for each Medicare-covered individual therapy visit with a psychiatrist</p> <p>\$25 copay for each Medicare-covered group therapy visit with a psychiatrist</p> <p>\$10 for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network \$45 copay for Mental Health benefits with a psychiatrist</p> <p>\$45 copay for Mental Health benefits</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered Mental Health visits</p> <p>\$0 for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network \$35 copay for Mental Health benefits with a psychiatrist</p> <p>\$35 copay for Mental Health benefits</p> <p>\$35 for Medicare-covered partial hospitalization program services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered Mental Health visits</p> <p>\$0 for Medicare-covered partial hospitalization program services</p> <p>Out-of-Network \$35 copay for Mental Health benefits with a psychiatrist</p> <p>\$35 copay for Mental Health benefits</p> <p>\$35 for Medicare-covered partial hospitalization program services</p>

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<p>11 - Outpatient Mental Health Care <i>continued</i></p>		<p>\$45 copay for Mental Health benefits</p> <p>\$50 copay for partial hospitalization program services</p>
<p>12 - Outpatient Substance Abuse Care</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits</p> <p>\$30 copay for Medicare-covered group visits</p> <p>Out-of-Network \$45 copay for outpatient substance abuse benefits.</p>
<p>13 - Outpatient Services/Surgery</p>	<p>20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible.</p> <p>20% coinsurance for ambulatory surgical center facility services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$115 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$115 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network \$215 copay for outpatient hospital facility benefits.</p> <p>\$215 copay for ambulatory surgical center benefits.</p>

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\$40 copay for partial hospitalization program services	\$40 copay for partial hospitalization program services		
<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered individual visits</p> <p>\$10 copay for Medicare-covered group visits</p> <p>Out-of-Network \$40 copay for outpatient substance abuse benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered individual visits</p> <p>\$10 copay for Medicare-covered group visits</p> <p>Out-of-Network \$40 copay for outpatient substance abuse benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered visits</p> <p>Out-of-Network \$35 copay for outpatient substance abuse benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered visits</p> <p>Out-of-Network \$35 copay for outpatient substance abuse benefits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$40 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network \$100 copay for outpatient hospital facility benefits.</p> <p>\$100 copay for ambulatory surgical center benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$40 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$40 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network \$100 copay for outpatient hospital facility benefits.</p> <p>\$100 copay for ambulatory surgical center benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network \$100 copay for outpatient hospital facility benefits.</p> <p>\$100 copay for ambulatory surgical center benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit</p> <p>Out-of-Network \$100 copay for outpatient hospital facility benefits.</p> <p>\$100 copay for ambulatory surgical center benefits.</p>

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<p>14 - Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>In-Network \$95 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$95 copay for ambulance benefits.</p>
<p>15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.</p> <p>Not covered outside the U.S. except under limited circumstances.</p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p> <p>\$100,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p><i>See page <70 and 71 > for additional information about Emergency Care.</i></p>
<p>16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$50 copay for Medicare-covered urgently-needed-care visits</p>

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<p>In-Network \$75 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$75 copay for ambulance benefits.</p>	<p>In-Network \$75 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$75 copay for ambulance benefits.</p>	<p>In-Network \$65 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$65 copay for ambulance benefits.</p>	<p>In-Network \$65 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$65 copay for ambulance benefits.</p>
<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p> <p>\$100,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p><i>See page <70 and 71 > for additional information about Emergency Care.</i></p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p> <p>\$100,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p><i>See page <70 and 71 > for additional information about Emergency Care.</i></p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p> <p>\$100,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p><i>See page <70 and 71 > for additional information about Emergency Care.</i></p>	<p>General \$65 copay for Medicare-covered emergency room visits</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p> <p>\$100,000 plan coverage limit for emergency services outside the U.S. every year.</p> <p><i>See page <70 and 71 > for additional information about Emergency Care.</i></p>
<p>General \$40 copay for Medicare-covered urgently-needed-care visits</p>	<p>General \$40 copay for Medicare-covered urgently-needed-care visits</p>	<p>General \$40 copay for Medicare-covered urgently-needed-care visits</p>	<p>General \$40 copay for Medicare-covered urgently-needed-care visits</p>

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<p>17 - Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered Occupational Therapy visits</p> <p>\$30 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network \$35 copay for Occupational Therapy benefits.</p> <p>\$35 copay for Physical and/or Speech and Language Therapy visits.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p>		
<p>18 - Durable Medical Equipment</p> <p>(includes wheelchairs, oxygen, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 30% of the cost for durable medical equipment</p>

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network \$35 copay for Occupational Therapy benefits.</p> <p>\$35 copay for Physical and/or Speech and Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 copay for Medicare-covered Occupational Therapy visits</p> <p>\$25 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network \$35 copay for Occupational Therapy benefits.</p> <p>\$35 copay for Physical and/or Speech and Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network \$25 copay for Occupational Therapy benefits.</p> <p>\$25 copay for Physical and/or Speech and Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits</p> <p>\$0 copay for Medicare-covered Physical and/or Speech and Language Therapy visits</p> <p>Out-of-Network \$25 copay for Occupational Therapy benefits.</p> <p>\$25 copay for Physical and/or Speech and Language Therapy visits.</p>
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 30% of the cost for durable medical equipment</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 30% of the cost for durable medical equipment</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for Medicare-covered items less than or equal to \$300, 10% copay for Medicare covered items greater than \$300</p> <p>Out-of-Network \$30 copay for Medicare-covered items less than or equal to \$300, 20% copay for Medicare covered items greater than \$300</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for Medicare-covered items less than or equal to \$300, 10% copay for Medicare covered items greater than \$300</p> <p>Out-of-Network \$30 copay for Medicare-covered items less than or equal to \$300, 20% copay for Medicare covered items greater than \$300</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 30% of the cost for prosthetic devices.</p> <p><i>See page <71 >for additional information about Prosthetic Devices.</i></p>
<p>20 - Diabetes Programs and Supplies</p>	<p>20% coinsurance for diabetes self-management training</p> <p>20% coinsurance for diabetes supplies</p> <p>20% coinsurance for diabetic therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$15 copay for Diabetes monitoring supplies</p> <p>\$15 copay for Therapeutic shoes or inserts</p> <p>Out-of-Network \$0 copay for Diabetes self-management training</p> <p>\$40 of the cost for Diabetes monitoring supplies</p> <p>\$40 of the cost for Therapeutic shoes or inserts</p>

Summary of Benefits Report

Network PlatinumPlus(PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 30% of the cost for prosthetic devices.</p> <p><i>See page <71 >for additional information about Prosthetic Devices.</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items</p> <p>Out-of-Network 30% of the cost for prosthetic devices.</p> <p><i>See page <71 >for additional information about Prosthetic Devices.</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% of the cost for Medicare-covered items</p> <p>Out-of-Network 20% of the cost for prosthetic devices.</p> <p><i>See page <71 >for additional information about Prosthetic Devices.</i></p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% of the cost for Medicare-covered items</p> <p>Out-of-Network 20% of the cost for prosthetic devices.</p> <p><i>See page <71 >for additional information about Prosthetic Devices.</i></p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$10 copay for Diabetes monitoring supplies</p> <p>\$10 copay for Therapeutic shoes or inserts</p> <p>Out-of-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$10 copay for Diabetes monitoring supplies</p> <p>\$10 copay for Therapeutic shoes or inserts</p> <p>Out-of-Network \$0 copay for Diabetes self-management training</p> <p>20% of the cost for Diabetes monitoring supplies</p> <p>20% of the cost for Therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$0 copay for Diabetes monitoring supplies</p> <p>\$0 copay Therapeutic shoes or inserts</p> <p>Out-of-Network \$35 copay for Diabetes self-management training</p> <p>10% of the cost for Diabetes monitoring supplies</p> <p>10% of the cost for Therapeutic shoes or inserts</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-management training</p> <p>\$0 copay for Diabetes monitoring supplies</p> <p>\$0 copay Therapeutic shoes or inserts</p> <p>Out-of-Network \$35 copay for Diabetes self-management training</p> <p>10% of the cost for Diabetes monitoring supplies</p> <p>10% of the cost for Therapeutic shoes or inserts</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab Services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.</p> <p>20% coinsurance for digital rectal exam and other related services. Covered once a year for all men with Medicare over age 50.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered: - lab services - diagnostic procedures and tests</p> <p>\$20 copay for Medicare-covered X-rays</p> <p>\$60 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p> <p>20% copay for Medicare-covered therapeutic radiology services</p> <p>Out-of-Network 30% of the cost for outpatient X-rays</p> <p>\$20 copay for diagnostic procedures, tests, and lab services</p> <p>\$125 copay for diagnostic radiology services</p> <p>30% of the cost for therapeutic radiology services</p>
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Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>
<p>In-Network \$0 to \$3 copay for Medicare-covered lab services</p>	<p>In-Network \$0 to \$3 copay for Medicare-covered lab services</p>	<p>In-Network \$0 copay for Medicare-covered:</p>	<p>In-Network \$0 copay for Medicare-covered:</p>
<p>\$0 to \$3 copay for Medicare-covered diagnostic procedures and tests</p>	<p>\$0 to \$3 copay for Medicare-covered diagnostic procedures and tests</p>	<ul style="list-style-type: none"> - lab services - diagnostic procedures and tests 	<ul style="list-style-type: none"> - lab services - diagnostic procedures and tests
<p>\$20 copay for Medicare-covered X-rays</p>	<p>\$20 copay for Medicare-covered X-rays</p>	<ul style="list-style-type: none"> - X-rays 	<ul style="list-style-type: none"> - X-rays
<p>\$50 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p>	<p>\$50 copay for Medicare-covered diagnostic radiology services (not including X-rays)</p>	<ul style="list-style-type: none"> - diagnostic radiology services (not including X-rays) - therapeutic radiology services 	<ul style="list-style-type: none"> - diagnostic radiology services (not including X-rays) - therapeutic radiology services
<p>\$20 copay for Medicare-covered therapeutic radiology services</p>	<p>\$20 copay for Medicare-covered therapeutic radiology services</p>	<p>Out-of-Network \$30 copay for outpatient X-rays</p>	<p>Out-of-Network \$30 copay for outpatient X-rays</p>
<p>Out-of-Network \$35 copay for outpatient X-rays</p>	<p>Out-of-Network \$35 copay for outpatient X-rays</p>	<p>\$25 copay for diagnostic procedures, tests, and lab services</p>	<p>\$25 copay for diagnostic procedures, tests, and lab services</p>
<p>\$3 copay for diagnostic procedures, tests, and lab services</p>	<p>\$3 copay for diagnostic procedures, tests, and lab services</p>	<p>\$50 copay for diagnostic radiology services</p>	<p>\$50 copay for diagnostic radiology services</p>
<p>\$125 copay for diagnostic radiology services</p>	<p>\$125 copay for diagnostic radiology services</p>	<p>\$35 copay for therapeutic radiology services</p>	<p>\$35 copay for therapeutic radiology services</p>
<p>10% of the cost for therapeutic radiology services</p>	<p>10% of the cost for therapeutic radiology services</p>		

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>22 - Cardiac and Pulmonary Rehabilitation Services</p>	<p>20% coinsurance Cardiac Rehabilitation services</p> <p>20% coinsurance for Pulmonary Rehabilitation services</p> <p>20% coinsurance for Intensive Cardiac Rehabilitation services</p> <p>This applies to program services provided in a doctor’s office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered Cardiac Rehabilitation Services</p> <p>\$30 copay for Medicare-covered Intensive Cardiac Rehabilitation Services</p> <p>\$30 copay for Medicare-covered Pulmonary Rehabilitation Services</p> <p>Out-of-Network \$40 copay for Cardiac Rehabilitation Services</p> <p>\$40 copay for Intensive Cardiac Rehabilitation Services</p> <p>\$40 copay for Pulmonary Rehabilitation Services</p>
<p>PREVENTIVE SERVICES</p>		
<p>23 - Preventive Services and Wellness/Education Programs</p>	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm Screening ▪ Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. ▪ Cardiovascular Screening ▪ Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine 	<p>General</p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm screening ▪ Bone Mass Measurement ▪ Cardiovascular Screening

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Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.
In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services	In-Network \$10 copay for Medicare-covered Cardiac Rehabilitation Services	In-Network \$0 copay for: - Medicare-covered Cardiac Rehabilitation Services	In-Network \$0 copay for: - Medicare-covered Cardiac Rehabilitation Services
\$10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services	\$10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services	- Medicare-covered Intensive Cardiac Rehabilitation Services	- Medicare-covered Intensive Cardiac Rehabilitation Services
\$10 copay for Medicare-covered Pulmonary Rehabilitation Services	\$10 copay for Medicare-covered Pulmonary Rehabilitation Services	- Medicare-covered Pulmonary Rehabilitation Services	- Medicare-covered Pulmonary Rehabilitation Services
Out-of-Network \$40 copay for Cardiac Rehabilitation Services	Out-of-Network \$40 copay for Cardiac Rehabilitation Services	Out-of-Network \$35 copay for Cardiac Rehabilitation Services	Out-of-Network \$35 copay for Cardiac Rehabilitation Services
\$40 copay for Intensive Cardiac Rehabilitation Services	\$40 copay for Intensive Cardiac Rehabilitation Services	\$35 copay for Intensive Cardiac Rehabilitation Services	\$35 copay for Intensive Cardiac Rehabilitation Services
\$40 copay for Pulmonary Rehabilitation Services	\$40 copay for Pulmonary Rehabilitation Services	\$35 copay for Pulmonary Rehabilitation Services	\$35 copay for Pulmonary Rehabilitation Services
General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm screening ▪ Bone Mass Measurement ▪ Cardiovascular Screening 	General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm screening ▪ Bone Mass Measurement ▪ Cardiovascular Screening 	General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm screening ▪ Bone Mass Measurement ▪ Cardiovascular Screening 	General \$0 copay for all preventive services covered under Original Medicare at zero cost sharing: <ul style="list-style-type: none"> ▪ Abdominal Aortic Aneurysm screening ▪ Bone Mass Measurement ▪ Cardiovascular Screening

Summary of Benefits Report

Benefit Category

Original Medicare

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<p>23 - Preventive Services and Wellness/Education Programs <i>continued</i></p>	<ul style="list-style-type: none"> ▪ Hepatitis B Vaccine for people with Medicare who are at risk ▪ HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. ▪ Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. ▪ Medical Nutrition Therapy Services Nutrition therapy is for people who have diabetes or kidney disease (but aren’t on dialysis or haven’t had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. ▪ Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. ▪ Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. ▪ Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. 	<ul style="list-style-type: none"> ▪ Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine ▪ Hepatitis B Vaccine ▪ HIV Screening ▪ Breast Cancer Screening (Mammogram) ▪ Medical Nutrition Therapy Services ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine ▪ Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ▪ Smoking Cessation (Counseling to stop smoking) ▪ Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) <p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>
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Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<ul style="list-style-type: none"> ▪ Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine ▪ Hepatitis B Vaccine ▪ HIV Screening ▪ Breast Cancer Screening (Mammogram) ▪ Medical Nutrition Therapy Services ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine ▪ Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ▪ Smoking Cessation (Counseling to stop smoking) ▪ Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) 	<ul style="list-style-type: none"> ▪ Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine ▪ Hepatitis B Vaccine ▪ HIV Screening ▪ Breast Cancer Screening (Mammogram) ▪ Medical Nutrition Therapy Services ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine ▪ Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ▪ Smoking Cessation (Counseling to stop smoking) ▪ Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) 	<ul style="list-style-type: none"> ▪ Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine ▪ Hepatitis B Vaccine ▪ HIV Screening ▪ Breast Cancer Screening (Mammogram) ▪ Medical Nutrition Therapy Services ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine ▪ Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ▪ Smoking Cessation (Counseling to stop smoking) ▪ Welcome to Medicare Physical Exam (Initial Preventive Physical Exam) 	<ul style="list-style-type: none"> ▪ Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) ▪ Colorectal Cancer Screening ▪ Diabetes Screening ▪ Influenza Vaccine ▪ Hepatitis B Vaccine ▪ HIV Screening ▪ Breast Cancer Screening (Mammogram) ▪ Medical Nutrition Therapy Services ▪ Personalized Prevention Plan Services (Annual Wellness Visits) ▪ Pneumococcal Vaccine ▪ Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) ▪ Smoking Cessation (Counseling to stop smoking) ▪ Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)
<p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>	<p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>	<p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>	<p>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>23 - Preventive Services and Wellness/Education Programs <i>continued</i></p>		<p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Nutritional benefit ▪ Additional Smoking Cessation ▪ Health Club Membership/ Fitness Classes ▪ Nursing Hotline <p>Out-of-Network 50% of the cost for supplemental education/wellness programs</p> <p>\$20 copay for Medicare-covered preventive services</p> <p>\$20 copay for supplemental education/wellness programs</p> <p>\$35 copay for supplemental preventive services</p> <p><i>See page <71, 72, 73 and 75> for additional information about Preventive Services and Wellness/Education Programs.</i></p>
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Summary of Benefits Report

Network PlatinumPlus(PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Nutritional benefit ▪ Additional Smoking Cessation ▪ Health Club Membership/ Fitness Classes ▪ Nursing Hotline <p>Out-of-Network \$35 copay for Medicare-covered preventive services</p> <p>\$35 copay for supplemental preventive services</p> <p>\$35 copay for supplemental education/wellness programs</p> <p>50% of the cost for supplemental education/wellness programs</p> <p><i>See page <71, 72, 73 and 75>for additional information about Preventive Services and Wellness/Education Programs.</i></p>	<p>In-Network The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Nutritional benefit ▪ Additional Smoking Cessation ▪ Health Club Membership/ Fitness Classes ▪ Nursing Hotline <p>Out-of-Network \$35 copay for Medicare-covered preventive services</p> <p>\$35 copay for supplemental preventive services</p> <p>\$35 copay for supplemental education/wellness programs</p> <p>50% of the cost for supplemental education/wellness programs</p> <p><i>See page <71, 72, 73 and 75> for additional information about Preventive Services and Wellness/Education Programs.</i></p>	<p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> ▪ up to 1 additional pap smear every year ▪ up to 1 additional pelvic exam every year <p>The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Nutritional benefit ▪ Additional Smoking Cessation ▪ Health Club Membership/ Fitness Classes ▪ Nursing Hotline <p>Out-of-Network \$35 copay for Medicare-covered preventive services</p> <p>\$35 copay for supplemental preventive services</p> <p>\$35 copay for supplemental education/wellness programs</p> <p>50% of the cost for supplemental education/wellness programs</p> <p><i>See page <71, 72, 73 and 75> for additional information about Preventive Services and Wellness/Education Programs.</i></p>	<p>In-Network \$0 copay for:</p> <ul style="list-style-type: none"> ▪ up to 1 additional pap smear every year ▪ up to 1 additional pelvic exam every year <p>The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> ▪ Written health education materials, including Newsletters ▪ Nutritional benefit ▪ Additional Smoking Cessation ▪ Health Club Membership/ Fitness Classes ▪ Nursing Hotline <p>Out-of-Network \$35 copay for Medicare-covered preventive services</p> <p>\$35 copay for supplemental preventive services</p> <p>\$35 copay for supplemental education/wellness programs</p> <p>50% of the cost for supplemental education/wellness programs</p> <p><i>See page <71, 72, 73 and 75> for additional information about Preventive Services and Wellness/Education Programs.</i></p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>24 - Kidney Disease and Conditions</p>	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for kidney disease education services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network \$20 copay for kidney disease education services</p> <p>\$40 copay for renal dialysis</p>
<p>25 - Outpatient Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.nppdrugplans.com/find_your_prescriptions/ on the web.</p>

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network \$40 copay for renal dialysis</p> <p>\$40 copay for kidney disease education services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network \$40 copay for renal dialysis</p> <p>\$40 copay for kidney disease education services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network \$35 copay for renal dialysis</p> <p>\$35 copay for kidney disease education services</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for renal dialysis</p> <p>\$0 copay for kidney disease education services</p> <p>Out-of-Network \$35 copay for renal dialysis</p> <p>\$35 copay for kidney disease education services</p>
<p>Drugs covered under Medicare Part B</p> <p>General Most drugs not covered.</p> <p>15% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>25% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>15% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>25% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.nppdrugplans.com/find_your_prescriptions/ on the web.</p>	<p>Drugs covered under Medicare Part B</p> <p>General Most drugs not covered.</p> <p>12% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General</p> <p>12% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.nppdrugplans.com/find_your_prescriptions/ on the web.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p>		<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> ▪ have limited incomes, ▪ live in long term care facilities, or ▪ have access to ▪ Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Network PlatinumSelect (PPO) for certain drugs.</p>
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Summary of Benefits Report

Network
Platinum*Plus*(PPO)

Network
Platinum*Plus*
Pharmacy (PPO)

Network
Platinum*Premier* (PPO)

Network
Platinum*Premier*
Pharmacy (PPO)

	<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> ▪ have limited incomes, ▪ live in long term care facilities, or ▪ have access to ▪ Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Network PlatinumPlus Pharmacy (PPO) for certain drugs.</p>		<p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> ▪ have limited incomes, ▪ live in long term care facilities, or ▪ have access to ▪ Indian/Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and a Part D plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits.</p> <p>Your provider must get prior authorization from Network PlatinumPremier Pharmacy (PPO) for certain drugs.</p>
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Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p>		<p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Network PlatinumSelect (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.</p>
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Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Network Platinum<i>Plus</i> Pharmacy (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.</p>		<p>The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.</p> <p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Network Platinum<i>Premier</i> Pharmacy (PPO) approves the exception, you will pay Tier 2: Preferred Brand Drugs cost sharing for that drug.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ In-Network 		<p>\$0 deductible.</p>
<ul style="list-style-type: none"> ▪ Initial Coverage 		<p>You pay the following until total yearly drug costs reach \$2,930:</p>
<ul style="list-style-type: none"> ▪ Retail Pharmacy 		<p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$19 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$12 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$92 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	\$0 deductible.		\$0 deductible.
	You pay the following until total yearly drug costs reach \$2,930:		You pay the following until total yearly drug costs reach \$2,930:
	<p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$19 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$12 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$92 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy 		<p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$19 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$12 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$24 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred pharmacy <p>Tier 2: Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$92 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ Retail Pharmacy <i>continued</i> 		<p>- \$40 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>- \$97 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred Pharmacy</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy</p> <p>- \$184 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy</p> <p>- \$70 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy</p> <p>- \$189 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred Pharmacy</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy</p>
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Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$97 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred Pharmacy <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$65 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$184 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$70 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$189 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred Pharmacy <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy 		<ul style="list-style-type: none"> - \$40 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$97 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred Pharmacy <p>Tier 3: Non-Preferred Brand Drugs</p> <ul style="list-style-type: none"> - \$65 copay for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - \$184 copay for a three-month (90-day) supply of drugs in this tier from a preferred pharmacy - \$70 copay for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy - \$189 copay for a three-month (90-day) supply of drugs in this tier from a non-preferred Pharmacy <p>Tier 4: Specialty Tier Drugs</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a preferred pharmacy - 33% coinsurance for a one-month (31-day) supply of drugs in this tier from a non-preferred pharmacy

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ Long Term Care Pharmacy 		<p>Tier 1: Preferred Generic Drugs</p> <p>- \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>
<ul style="list-style-type: none"> ▪ Mail Order 		<p>Tier 1: Preferred Generic Drugs</p> <p>- \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p>

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>Tier 1: Preferred Generic Drugs</p> <p>- \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>		<p>Tier 1: Preferred Generic Drugs</p> <p>- \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>
	<p>Tier 1: Preferred Generic Drugs</p> <p>- \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p>		<p>Tier 1: Preferred Generic Drugs</p> <p>- \$7 copay for a one-month (31-day) supply of drugs in this tier</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ Mail Order <i>continued</i> 		<p>- \$92 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier - \$184 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>
<ul style="list-style-type: none"> ▪ Coverage Gap 		<p>After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>
<ul style="list-style-type: none"> ▪ Additional Coverage Gap 		

Summary of Benefits Report

Network PlatinumPlus(PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>- \$92 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier - \$184 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>		<p>- \$92 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier - \$184 copay for a three-month (90-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p>
	<p><i>See page <73, 74 and 75> for additional information about Outpatient Prescription Drugs.</i></p>		<p><i>See page <73, 74 and 75> additional information about Outpatient Prescription Drugs.</i></p>
	<p>You pay the following:</p> <p>Retail Pharmacy Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred pharmacy - \$24 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy</p>		<p>You pay the following:</p> <p>Retail Pharmacy Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier from a preferred pharmacy - \$24 copay for a three-month (90-day) supply of all drugs covered in this tier from a preferred pharmacy</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

25 - Outpatient
Prescription Drugs
continued

- Additional
Coverage Gap
continued

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>- \$13 copay for a one-month (31-day) supply of all drugs covered in this tier at a non-preferred pharmacy</p> <p>- \$29 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier</p> <p>Mail Order Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier</p> <p>- \$24 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>		<p>- \$13 copay for a one-month (31-day) supply of all drugs covered in this tier at a non-preferred pharmacy</p> <p>- \$29 copay for a three-month (90-day) supply of all drugs covered in this tier from a non-preferred pharmacy</p> <p>Not all drugs on this tier are available at this extended day supply. Please contact the plan for more information.</p> <p>Long Term Care Pharmacy Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier</p> <p>Mail Order Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier</p> <p>- \$24 copay for a three-month (90-day) supply of all drugs covered in this tier</p> <p>After your total yearly drug costs reach \$2,930, you receive a discount on brand name drugs and pay 86% of the plan's costs for all generic drugs until your yearly out-of-pocket drug costs reach \$4,700.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ Catastrophic Coverage 		<p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> -5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.
<ul style="list-style-type: none"> ▪ Out-of-Network 		<p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Network PlatinumSelect (PPO).</p>
<ul style="list-style-type: none"> ▪ Out-of-Network Initial Coverage 		<p>You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> -5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. 		<p>After your yearly out-of-pocket drug costs reach \$4,700, you pay the greater of:</p> <ul style="list-style-type: none"> -5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs.
	<p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Network PlatinumPlus Pharmacy (PPO).</p>		<p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Network PlatinumPremier Pharmacy (PPO).</p>
	<p>You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of 		<p>You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,930:</p> <p>Tier 1: Preferred Generic Drugs</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ Out-of-Network Initial Coverage <i>continued</i> 		<p>drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
<ul style="list-style-type: none"> ▪ Additional Out-of-Network Coverage Gap 		<p>You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p>

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>		<p>drugs in this tier</p> <p>Tier 2: Preferred Brand Drugs</p> <p>- \$35 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- \$65 copay for a one-month (31-day) supply of drugs in this tier</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- 33% coinsurance for a one-month (31-day) supply of drugs in this tier</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
	<p>You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier</p>		<p>You will be reimbursed for these drugs purchased out-of-network up to the plan's cost of the drug minus the following:</p> <p>Tier 1: Preferred Generic Drugs</p> <p>- \$8 copay for a one-month (31-day) supply of all drugs covered in this tier</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

25 - Outpatient
Prescription Drugs
continued

- Additional Out-of-
Network
Coverage Gap
continued

You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>Tier 2: Preferred Brand Drugs</p> <p>- You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p>		<p>Tier 2: Preferred Brand Drugs</p> <p>- You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Tier 3: Non-Preferred Brand Drugs</p> <p>- You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>Tier 4: Specialty Tier Drugs</p> <p>- You will be reimbursed up to 14% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>25 - Outpatient Prescription Drugs <i>continued</i></p> <ul style="list-style-type: none"> ▪ Additional Out-of-Network Coverage Gap <i>continued</i> 		
<ul style="list-style-type: none"> ▪ Out-of-Network Catastrophic Coverage 		<p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
	<p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>		<p>You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach \$4,700.</p> <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>
	<p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>		<p>After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of:</p> <ul style="list-style-type: none"> - 5% coinsurance, or - \$2.60 copay for generic (including brand drugs treated as generic) and a \$6.50 copay for all other drugs. <p>You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>26 - Dental Services</p>	<p>Preventive dental services (such as cleaning) not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$30 copay for Medicare-covered dental benefits</p> <p>Out-of-Network \$45 copay for comprehensive dental benefits</p> <p><i>See page <72 >for additional information about Dental Services.</i></p>
<p>27 - Hearing Services</p>	<p>Supplemental routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network In general, supplemental routine hearing exams and hearing aids not covered.</p> <p>- \$30 copay for Medicare-covered diagnostic hearing exams</p> <p>Out-of-Network \$45 copay for hearing exams.</p> <p><i>See page < 75>for additional information about Hearing Services.</i></p>

Summary of Benefits Report

Network PlatinumPlus(PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$25 copay for Medicare-covered dental benefits</p> <p>Out-of-Network \$45 copay for comprehensive dental benefits</p> <p><i>See page <72 >for additional information about Dental Services.</i></p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$25 copay for Medicare-covered dental benefits</p> <p>Out-of-Network \$45 copay for comprehensive dental benefits</p> <p><i>See page < 72>for additional information about Dental Services.</i></p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>Out-of-Network \$30 copay for comprehensive dental benefits</p> <p><i>See page < 72>for additional information about Dental Services.</i></p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$0 copay for Medicare-covered dental benefits</p> <p>Out-of-Network \$30 copay for comprehensive dental benefits</p> <p><i>See page <72 >for additional information about Dental Services.</i></p>
<p>In-Network In general, supplemental routine hearing exams and hearing aids not covered.</p> <p>- \$25 copay for Medicare-covered diagnostic hearing exams</p> <p>Out-of-Network \$45 copay for hearing exams.</p> <p><i>See page <75 >for additional information about Hearing Services.</i></p>	<p>In-Network In general, supplemental routine hearing exams and hearing aids not covered.</p> <p>- \$25 copay for Medicare-covered diagnostic hearing exams</p> <p>Out-of-Network \$45 copay for hearing exams.</p> <p><i>See page <75 >for additional information about Hearing Services.</i></p>	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams</p> <p>- up to 1 supplemental routine hearing exam every year</p> <p>Out-of-Network \$35 copay for hearing exams.</p> <p>In and Out-of-Network \$0 copay for up to 1 hearing aid every year</p> <p>\$100 plan coverage limit for supplemental routine hearing aids every year.</p> <p>This limit applies to both in-network and out-of-network benefits.</p>	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams</p> <p>- up to 1 supplemental routine hearing exam every year</p> <p>Out-of-Network \$35 copay for hearing exams.</p> <p>In and Out-of-Network \$0 copay for up to 1 hearing aid every year</p> <p>\$100 plan coverage limit for supplemental routine hearing aids every year.</p> <p>This limit applies to both in-network and out-of-network benefits.</p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

<p>27 - Hearing Services <i>continued</i></p>		
<p>28 - Vision Services</p>	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <ul style="list-style-type: none"> - \$30 copay for one pair of eyeglasses or contact lenses after cataract surgery. - \$0 to \$30 copay for exams to diagnose and treat diseases and conditions of the eye. <p>Out-of-Network</p> <ul style="list-style-type: none"> \$45 copay for eye exams. \$45 copay for eye wear. <p>In and Out-of-Network</p> <ul style="list-style-type: none"> - \$0 copay for up to 1 pair of glasses every year - \$0 copay for up to 12 pair(s) of contacts every year \$100 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits. <p><i>See page < 75>for additional information about Vision Services.</i></p>

Summary of Benefits Report

Network PlatinumPlus(PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
		<i>See page <75 >for additional information about Hearing Services.</i>	<i>See page <75 >for additional information about Hearing Services.</i>
<p>In-Network - \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>- \$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>Out-of-Network \$45 copay for eye exams.</p> <p>\$45 copay for eye wear.</p> <p>In and Out-of-Network - \$0 copay for up to 1 pair of glasses every year</p> <p>- \$0 copay for up to 12 pair(s) of contacts every year</p> <p>\$100 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.</p> <p><i>See page <75 >for additional information about Vision Services</i></p>	<p>In-Network - \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>- \$0 to \$25 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>Out-of-Network \$45 copay for eye exams.</p> <p>\$45 copay for eye wear.</p> <p>In and Out-of-Network - \$0 copay for up to 1 pair of glasses every year</p> <p>- \$0 copay for up to 12 pair(s) of contacts every year</p> <p>\$100 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.</p> <p><i>See page <75 >for additional information about Vision Services</i></p>	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <p>- and up to 1 supplemental routine eye exam(s) every year</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</p> <p>Out-of-Network \$35 copay for eye exams.</p> <p>\$35 copay for eye wear.</p> <p>In and Out-of-Network - \$0 copay for up to 1 pair of glasses every year</p> <p>- \$0 copay for up to 12 pair(s) of contacts every year</p> <p>\$125 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.</p> <p><i>See page <75 >for additional information about Vision Services</i></p>	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <p>- and up to 1 supplemental routine eye exam(s) every year</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</p> <p>Out-of-Network \$35 copay for eye exams.</p> <p>\$35 copay for eye wear.</p> <p>In and Out-of-Network - \$0 copay for up to 1 pair of glasses every year</p> <p>- \$0 copay for up to 12 pair(s) of contacts every year</p> <p>\$100 plan coverage limit for eye wear every year. This limit applies to both in-network and out-of-network benefits.</p> <p><i>See page <75 >for additional information about Vision Service</i></p>

Summary of Benefits Report

Benefit Category

Original Medicare

Network
PlatinumSelect (PPO)

Over-the-Counter Items	Not covered.	General The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered	In-Network This plan does not cover supplemental routine transportation.
Acupuncture	Not covered	In-Network This plan does not cover Acupuncture.

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
<p>General The plan does not cover Over-the-Counter items.</p>	<p>General The plan does not cover Over-the-Counter items.</p>	<p>General The plan does not cover Over-the-Counter items.</p>	<p>General The plan does not cover Over-the-Counter items.</p>
<p>In-Network This plan does not cover supplemental routine transportation.</p>	<p>In-Network This plan does not cover supplemental routine transportation.</p>	<p>In-Network This plan does not cover supplemental routine transportation.</p>	<p>In-Network This plan does not cover supplemental routine transportation.</p>
<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>

Important Plan Information to the Summary of Benefits for NHIC Medicare Advantage Plans

Network Health Insurance Corporation – The Company You Can Trust

Network Health Insurance Corporation is a Medicare Advantage Preferred Provider Organization (PPO) with a Medicare contract. Network Health Plan has been meeting the needs of people in the Fox Valley since 1982. We have had a contract with Medicare and have provided health insurance coverage for our local seniors and others on Medicare since 1994. From the beginning, we've built a reputation for providing quality care to individuals and to employees of companies all over the area. Now we offer that same quality of care in our Medicare Advantage PPO products.

Caring, Personalized Customer Service – Delivered Locally

Even before you enroll, our entire staff is dedicated to providing you with the personalized service you deserve. We are here to answer your questions about our Network Platinum Medicare Advantage Plans and how they will meet your needs. If you like, you may come to our home office in Menasha, Wisconsin to meet with a member of our sales staff or have a representative arrange to meet with you at a convenient time and location.

As a member of a Network Platinum Medicare Advantage Plan, you are assigned a personal Health Care Concierge (HCC) along with a direct phone number to reach your concierge at the Network Health Insurance Corporation home office in Menasha, Wisconsin. Your HCC is your personal customer service representative and direct contact who can answer any questions or address any concerns you have regarding your health plan. Here at Network Health Insurance Corporation, our Customer Service Team is what sets us apart! Your Health Care Concierge promises to deliver quality service with hometown connections and your satisfaction in mind!

Pre-authorization

Some of the covered services listed in the Benefits Chart in this summary require “prior authorization,” which means approval in advance. These specific services are covered only if your contracted doctor or provider requests and receives prior authorization from Network Health Insurance Corporation. As a member you are never required to obtain prior authorization.

Emergency Care

Emergency Room Visits have the same co-pay whether the hospital is in network or out of network. If you are admitted as an Inpatient within 24 hours for the same condition, your co-pay is waived for the emergency room visit. If you get Inpatient care at an out-of-network hospital while after your emergency condition is stabilized, your cost-share is the same as you would pay at an in-network hospital.

Observation Bed Care (Partial Hospitalization)

If a patient is admitted for observation care following an emergency room visit, the patient's status is considered outpatient. Observation care is ongoing short term treatment, assessment, and reassessment of the patient's condition while a decision is being made to admit the patient for further treatment or discharge the patient which is generally within 48 hours. It will feel like you have been admitted, many times you are placed in a patient room in the hospital. It is always wise to ask the hospital staff if you are in an observation bed.

Self-Administered Drugs (SAD)

Self-Administered Drugs (SAD) are those medications you take on a regular basis. If during an Emergency Room Visit, a period of Observation Care, or an Out-Patient Surgery Visit you receive Self-Administered Drugs (SAD), you are responsible for the cost of the Self-Administered Drugs (SAD). If you have one of our plans that includes Part D prescription drugs - Network

Important Plan Information to the Summary of Benefits for NHIC Medicare Advantage Plans

PlatinumSelect (PPO), Network PlatinumPlus Pharmacy (PPO), or Network PlatinumPremier Pharmacy (PPO) - you may request reimbursement for SAD less your Part D co-pays.

Travel Benefit

Within the United States When you are traveling outside the state of Wisconsin and need medical care in the remaining 49 states, please show your Network Platinum Plan Member ID card, and you will receive your benefits at the lower in-network cost sharing amount. This applies to all Medicare covered services including non-emergent care from providers who accept Medicare assignment.

In addition, over 50,000 pharmacies are available to fill your prescriptions nationwide while traveling through our 50 United States. Please call the number on the back of your card for assistance in finding a pharmacy.

NOTE: Except in emergencies, please make sure the provider accepts Medicare Assignment. If a provider does not accept Medicare Assignment, they will be allowed to charge up to 15% over and above Medicare assignment, this additional amount is called the “Medicare limiting charge”. You will be responsible for this additional charge. This means you will pay more.

Outside the United States Emergency and urgent care services are covered outside of the United States. Your cost share will be 25% (we will pay 75%) up to an annual maximum of \$100,000. This does not cover the cost of air transportation back to the United States.

Skilled Nursing Facility Care (SNF)

Includes semi-private room, meals, skilled nursing and rehabilitative services, and other services and supplies that are medically necessary after a 3-day minimum inpatient hospital stay for a related illness or injury. In addition, you must have been

transferred to a participating SNF within 30 days after discharge from the hospital.

An inpatient hospital stay begins the day you’re formally admitted with a doctor’s order and doesn’t include the day you’re discharged. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care. Medicare doesn’t cover long-term care or custodial care. If at any time your care is no longer both skilled and rehabilitative, you no longer qualify for the Skilled Nursing benefit.

Custodial Care—Non-skilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn’t pay for custodial care.

Skilled Nursing Facility (SNF) Care—Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility.

Prosthetic devices and related supplies

Prosthetic devices are those devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices.

Vaccines

All of our Network Platinum Medicare Advantage PPO Plans cover the following vaccines with no co-pay:

Important Plan Information to the Summary of Benefits for NHIC Medicare Advantage Plans

- Influenza Vaccine (Flu Vaccine)
- Pneumococcal Vaccine (Pneumonia Vaccine)
- Hepatitis B Vaccine

We also cover some vaccines under our outpatient prescription drug benefit (Part D). Network Platinum*Select*, Network Platinum*Plus* Pharmacy, and Network Platinum*Premier* Pharmacy include Part D prescription drug benefits. This includes the Zostavax (Shingles) Vaccine.

Dental

Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.

Preventive dental benefits (such as cleaning) are not covered.

Health and Wellness Benefits

Network Health Insurance Corporation offers a variety of Health Education and Disease Management services. They include:

- Written health education materials, including newsletters
- Smoking cessation
- Nutritional training and benefits
- Nurse*Direct* Nurse hotline
- Stepping On Falls Prevention Program
- Living Well with Chronic Conditions
- Living Well with Diabetes
- Disease Management Program
- Care Management Services

Stepping On Falls Prevention Program is designed to help seniors stay safe and maintain their independence at home and in the community.

Members will learn simple balance and strength exercises as well as how vision, medication, diet, footwear and home hazards contribute to falls and injury. Expert guest speakers teach the exercises and present information on some of the topics.

Living Well Workshops are designed to help members with conditions such as diabetes, arthritis, high blood pressure, heart disease, chronic pain, and anxiety take charge of their lives. Members will find practical ways to deal with pain, fatigue, and stress, discover better nutrition and exercise choices, and learn better ways to talk with their doctor and family about their health.

The **Disease Management** program is staffed by health care professionals who provide information and educational programs that may help you manage chronic conditions effectively. These conditions include Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Heart Failure, and/or a Stroke related to vessel blockage. The services offered can:

- Provide disease-specific information
- Assist you to reach your goals for a healthier life
- Help simplify what you should know or do for your condition
- Offer educational programs, services or community events
- Help monitor your condition and offer opportunities for you to successfully manage your health

Care Managers & Care Management

Services work with you to manage your health conditions. They will educate you on the signs that a health condition is worsening and when you should contact your health care provider. They will also support you in managing your health conditions to increase your sense of well-being and put you in control of your health, coordinate your care with your health care providers, include you in your health care decision making and review your medications and treatments.

Colorectal screening

For people 50 and older, the following are covered:

- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months

Important Plan Information to the Summary of Benefits for NHIC Medicare Advantage Plans

▪ Fecal occult blood test, every 12 months
For people at high risk of colorectal cancer, we cover:

- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:

- Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy

Colonoscopies received at an ambulatory surgical center or outpatient hospital facility are subject to the appropriate outpatient surgery or hospital cost share.

Other Covered Benefits

The **Courage Program** is a wonderful program for our members who have heart disease or risk of heart disease. Members will be working with a Registered Nurse who will bring a team of health care professionals together for our members. The team includes a dietician, a pharmacist and an exercise physiologist. Our members work with this team to develop a plan to assist our members in preventing heart attacks and development of more serious heart and vascular illness.

The goal of the **Anti-Coagulation Therapy Clinic** is improved patient safety by helping members manage their therapy to reduce the potential for serious side effects of warfarin/Coumadin. After having their blood checked, members will receive immediate results, adjustments in treatment as necessary and a review of their treatment plan and education by a medical professional.

Maximum Out-of-Pocket Expenses

Network Platinum *Select*(PPO) Network Platinum*Plus*(PPO) and Network Platinum*Plus* Pharmacy(PPO) Network Platinum*Premier*(PPO)

and Network Platinum*Premier* Pharmacy(PPO) have a maximum you will pay out-of-pocket for Medicare-covered services. This maximum is combined in and out-of-network annually. The maximum excludes Part D prescription drug costs, Worldwide Emergency Care and the following supplemental services if applicable: Health Education/Wellness, Eyewear and Hearing Aids.

Prescription Drug Coverage

During Initial Coverage

As a member of Network Platinum *Select* (PPO), Network Platinum*Plus* Pharmacy (PPO) and Network Platinum*Premier* Pharmacy (PPO), you will pay a co-pay for your medications. If you get your prescription medications filled at a preferred pharmacy you will pay a lower co-pay than if the pharmacy you choose is a non-preferred pharmacy. (Preferred Pharmacies have signed an agreement to provide lower costs to our members. We pass that savings on to you.)

After you pay your co-pay based on drug tier, we will pay the remainder of the cost of your formulary medications during this initial period. Once total drug costs (what you and we pay together) reach \$2,930 you will enter the Coverage Gap.

During the Coverage Gap

Network Platinum *Select* (PPO), Network Platinum*Plus* Pharmacy (PPO) and Network Platinum*Premier* Pharmacy (PPO) will cover generic drugs once you reach \$2,930 in total drug costs per year (the coverage gap).

Network Platinum*Select* (PPO) covers generic drugs in the coverage gap as follows: You pay 86% and we pay 14% of generic drugs during the coverage gap.

Network Platinum*Plus* Pharmacy (PPO) and Network Platinum*Premier* Pharmacy (PPO) cover generic drugs in the coverage gap as follows: You pay \$8 copay at a preferred pharmacy (\$13 at non-preferred pharmacy) for a 31 day supply of Tier 1

Important Plan Information to the Summary of Benefits for NHIC Medicare Advantage Plans

generic drugs during the coverage gap. You pay 86% and we pay 14% of Tier 2, Tier 3, and Tier 4 generic drugs during the coverage gap.

Drug manufacturers' discount 50% of the cost and you pay the remaining 50% of the cost of Brand Name Drugs during the coverage gap.

During Catastrophic Coverage

We will resume covering generic and brand drugs after your total out-of-pocket of \$4,700 has been reached (catastrophic coverage). During Catastrophic Coverage, you will pay the greater of 5% or \$2.60 for generic drugs and the greater of 5% or \$6.50 for all other drugs. We will pay the remainder.

These payments are included in your total out-of-pocket costs.

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage).

- **The amount you pay for drugs when you are in any of the following drug payment stages:**
 - The Initial Coverage Stage
 - The Coverage Gap Stage.
- **The 50% Discount on Name Brand drugs provided by drug manufacturers during the Coverage Gap Stage**
- **Any payments you made during this calendar year under another Medicare prescription drug plan before you joined our plan.**

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by the Indian Health Service, or by a State Pharmaceutical Assistance Program that is qualified by Medicare.

- Payments made by Medicare's "Extra Help" and the Medicare Coverage Gap Discount Program are also included.

These payments are not included in your out-of-pocket costs.

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

How can you keep track of your Part D out-of-pocket total?

We will help you. The Explanation of Part D Prescription Drug plan Benefits report we send to you includes the current amount of your out-of-pocket costs. This statement will tell you how close you are to the Coverage Gap (\$2,930 of total drug costs). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

Important Plan Information to the Summary of Benefits for NHIC Medicare Advantage Plans

Medication Therapy Management is a voluntary program designed to improve your medication use and reduce the risk of adverse drug reactions. If you qualify and enroll in the program, you are eligible to receive a one-on-one Comprehensive Medication Review by telephone with a clinical pharmacist to review all your medications and identify any concerns. You will be mailed a medication list after this one-on-one session. Pharmacists will then review your medications at least every three months thereafter to identify new or unresolved medication issues. Based on these communications and reviews, you may receive additional written materials. Your physician may also be made aware of any concerns. This program is available at no cost to you.

Additional Benefits for members of our plans:

Health Club Membership

All Network Platinum(PPO) Plans include a Health Club benefit for our members.

- In-network health club: you will be reimbursed \$3 per visit up to 12 visits per month for a total of \$36 per month.
- Out-of-network health club: you will be reimbursed \$3 per visit up to 6 visits per month for a total of \$18 per month.

Preventive Services

Network PlatinumSelect (PPO), Network PlatinumPlus (PPO), Network PlatinumPlus Pharmacy (PPO), Network PlatinumPremier (PPO), and Network PlatinumPremier Pharmacy (PPO) include a lab screening with your Medicare Annual Wellness Visit. **It includes a lipid profile, glucose monitoring, and complete blood count analysis (CBC).** There is no co-pay for this visit and lab screening when seen by an in-network provider. A \$35 co-pay will be charged when performed by an out-of-network provider.

Routine Eye Exam and Routine Hearing Exam:

Network PlatinumPremier (PPO), and Network PlatinumPremier Pharmacy (PPO) cover 1 routine eye exam per year and 1 routine hearing exam per year. There is no copay in-network for the annual routine eye and hearing exams.

Eye glasses or contact lenses:

Network PlatinumSelect (PPO), Network PlatinumPlus (PPO), Network PlatinumPlus Pharmacy (PPO), and Network PlatinumPremier Pharmacy (PPO) cover up to \$100 maximum yearly toward the purchase of new eye glasses or contact lenses with any new eyeglass prescription (does not have to be following cataract surgery). Benefit does not include enhancements such as tinting, scratch coating etc.

Network PlatinumPremier (PPO) covers up to \$125 yearly. You are entitled to one pair of glasses per calendar year. Benefit does include enhancements such as tinting, scratch coating etc..

Hearing aides:

Network PlatinumPremier(PPO) and Network PlatinumPremier Pharmacy(PPO) cover up to a \$100 maximum toward the purchase of a new hearing aid each year.

For additional information on the services and the benefits available to you, contact Network Health Insurance Corporation Customer Service Department at 1-800-378-5234, Monday through Friday, 8 a.m. to 8 p.m. Hearing impaired may call TTY/TDD 1-800-947-3529.

Thank you for placing your confidence in Network Health Insurance Corporation's Network Platinum Medicare Advantage Plans. We look forward to serving you.

Network Health Insurance Corporation
1570 Midway Place
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<http://www.NPPdrugplans.com>

Network Platinum*Plus*
Network Platinum*Plus* Pharmacy
Network Platinum*Premier*
Network Platinum*Premier* Pharmacy
Network Platinum*Select*

