



Network PlatinumPlus Pharmacy (PPO) H5215

2012 EVIDENCE OF COVERAGE

MedicareRx
Prescription Drug Coverage X

 Network
PlatinumPlus™
AFFINITY HEALTH SYSTEM



January 1 – December 31, 2012

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Network Platinum*Plus* Pharmacy PPO

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Network Platinum*Plus* Pharmacy, is offered by Network Health Insurance Corporation. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Network Health Insurance Corporation. When it says “plan” or “our plan,” it means Network Platinum*Plus* Pharmacy).

Network Health Insurance Corporation is a Medicare Advantage Organization with a Medicare contract.

This information is available in alternate formats, including large print, Braille, and audio. Please call Customer Service at 1-800-378-5234, Monday thru Friday 8:00 am to 8:00 pm. From October 15, 2011 through February 14, 2012 we are available from 8:00 am to 8:00 pm, 7 days a week. TTY (hearing impaired) users call 1-800-947-3529, if you need plan information in another format or language.

Benefits, formulary, pharmacy network, premium, and/or copayments/coinsurance may change on January 1, 2013.

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- Medicare Part B is for most other medical services (such as physician’s services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for Network PlatinumPlus Pharmacy

Although Medicare is a Federal program, Network PlatinumPlus Pharmacy is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below:

Our service area includes these counties in Wisconsin: Brown, Calumet, Dodge, Fond du Lac, Green Lake, Manitowoc, Marquette, Outagamie, Portage, Shawano, Sheboygan, Waupaca, Waushara, and Winnebago.

If you plan to move out of the service area, please contact Customer Service. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here’s a sample membership card to show you what yours will look like:

Medical & Pharmacy Member ID Card

FRONT

Network PlatinumPlus
Pharmacy PPO
Medicare Advantage
Prescription Drug Plan

<Member Name>

Member # <000000000>
Effective Date: <mm/dd/yyyy>
Medical Group #: NPP<0000>
Issuer: 80840

CoPays: IN / Out
PCP: \$10 / \$20
Specialist:\$25/\$35
ER: \$65 / \$65

RxBin:<003858>
RxPCN: <MD>
RxGrp: <NHPA>



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BACK

Send Medical claims
to: Network Platinum
MA Plans
P.O. Box 3687
Scranton, PA 18505

Send Pharmacy
Claims to Network
Platinum MA Plans
P.O. Box 120
Menasha, WI 54952

Medical Customer Service: 1-800-378-5234
TTY/TDD: 1-800-947-3529
Medical Prior Authorization: 1-866-709-0019
Pharmacy Customer Service: 1-800-316-3107
TTY/TDD: 1-800-899-2114
Pharmacist Use Only: 1-800-235-4357
www.nppdrugplans.com

SAMPLE

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SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter tells things you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Network PlatinumPlus Pharmacy must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Network PlatinumPlus Pharmacy will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider who participates in Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *Provider Directory*.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a “PCP” and what does the PCP do for you?

When you become a member of our Plan, you may choose a plan provider to be your PCP. Your PCP is a Physician, Physician Assistant, or Nurse Practitioner who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. This Includes:

- X-rays
- Laboratory tests
- Routine preventative care, such as immunizations
- Follow Up Care

How do you choose your PCP?

Customer Service can assist you in finding a PCP, you can access the Directory of Providers to choose a provider, or you can use the website at <http://www.nppdrugplans.com> to see a complete list of providers available. You may also call NurseDirect at 1-800-362-9900.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

Customer Service or NurseDirect can assist you in selecting another PCP or provider.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer
- Cardiologists, who care for patients with heart conditions
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions

You do not need to get a referral from you PCP when obtaining services from any specialists or other plan professionals in our out-of-network. You can call the specialist's office directly or your PCP can help you arrange or coordinate the specialist visit. You are not limited to specialists or hospitals to which your PCP refers, but if the specialist or hospital is out-of-network, you may have a higher cost sharing amount.

If you need certain types of services, your PCP or specialist may need to get prior authorization (prior approval) from Network PlatinumPlus Pharmacy if that service is in-network. Out-of-Network providers and services do not require prior authorization. The services requiring prior authorization include:

- Hospitals inpatient services, behavioral health inpatient services, and skilled nursing facility stays
- Residential substance abuse or mental health treatment
- Specialty surgery such as bariatric surgery, deep brain stimulators and sleep apnea surgery
- Durable medical equipment, insulin pumps, continuous glucose monitoring devices, and oxygen over \$750.00
- Radiology imaging scans including CAT, MRI, MRA, PET and Nuclear Cardiology scans
- Home health care
- Outpatient physical, occupational and speech therapy services

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. You will be sent a letter informing you of the doctor's leaving the network of participating providers. You can refer to you Network Platinum Medicare Advantage Directory of Providers, call Customer Service (phone number is on the back cover of this booklet), or visit our website at <http://www.nppdrugplans.com> for help finding a new provider.

immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call Customer Service at the phone number on the back of your membership card or Care Management at 1-920-720-1602 or 1-866-709-0016.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

When Emergency Care is received **outside of the United States (worldwide coverage)** you will be responsible for 25% of the costs. Network PlatinumPlus Pharmacy will pay remaining 75% of costs up to the maximum \$100,000 every year. For more information, see the Medical Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you may pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency; the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network

providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2	Getting care when you have an urgent need for care
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What is “urgently needed care”?

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan’s network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

What if you are in the plan’s service area when you have an urgent need for care?

In most other situations, if you are in the plan’s service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

What if you are outside the plan’s service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider at the lower in-network cost-sharing amount.

When Urgent Care is received outside of the United States (worldwide coverage) you will be responsible for 25% of the costs. Network PlatinumPlus Pharmacy will pay remaining 75% of costs up to the maximum \$100,000 every year. For more information, see the Medical Benefits Chart in Chapter 4.

SECTION 4	What if you are billed directly for the full cost of your covered services?
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Section 4.1	You can ask the plan to pay our share of the cost of your covered services
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If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2	If services are not covered by our plan, you must pay the full cost
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Network PlatinumPlus Pharmacy covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Customer Service when you want to know how much of your benefit limit you have already used.

SECTION 5	How are your medical services covered when you are in a "clinical research study"?
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Section 5.1	What is a "clinical research study"?
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A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you

