



Network PlatinumPremier Pharmacy (PPO) H5215

2012 EVIDENCE OF COVERAGE

MedicareRx
Prescription Drug Coverage X

 Network
PlatinumPremier
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 PlatinumPremier 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 PlatinumPremier 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 PlatinumPremier 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 through 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.

H5215_005_ANEOC_R2 CMS File and Use 09112011

Chapter 1. Getting started as a member

| | | |
|------------------|--|----------|
| SECTION 1 | Introduction | 3 |
| Section 1.1 | You are enrolled in Network PlatinumPremier Pharmacy, which is a Medicare PPO | 3 |
| Section 1.2 | What is the <i>Evidence of Coverage</i> booklet about? | 3 |
| Section 1.3 | What does this Chapter tell you? | 3 |
| Section 1.4 | What if you are new to Network PlatinumPremier Pharmacy? | 3 |
| Section 1.5 | Legal information about the <i>Evidence of Coverage</i> | 4 |
| SECTION 2 | What makes you eligible to be a plan member? | 4 |
| Section 2.1 | Your eligibility requirements | 4 |
| Section 2.2 | What are Medicare Part A and Medicare Part B? | 4 |
| Section 2.3 | Here is the plan service area for Network PlatinumPremier Pharmacy | 5 |
| SECTION 3 | What other materials will you get from us? | 5 |
| Section 3.1 | Your plan membership card – Use it to get all covered care and prescription drugs | 5 |
| Section 3.2 | The <i>Provider Directory</i> : Your guide to all providers in the plan’s network | 6 |
| Section 3.3 | The <i>Pharmacy Directory</i> : Your guide to pharmacies in our network | 6 |
| Section 3.4 | The plan’s <i>List of Covered Drugs (Formulary)</i> | 7 |
| Section 3.5 | The <i>Explanation of Benefits</i> (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs | 7 |
| SECTION 4 | Your monthly premium for Network PlatinumPremier Pharmacy | 8 |
| Section 4.1 | How much is your plan premium? | 8 |
| Section 4.2 | There are several ways you can pay your plan premium | 9 |

| | | |
|------------------|---|-----------|
| Section 4.3 | Can we change your monthly plan premium during the year? | 11 |
| SECTION 5 | Please keep your plan membership record up to date..... | 11 |
| Section 5.1 | How to help make sure that we have accurate information about you | 11 |
| SECTION 6 | We protect the privacy of your personal health information | 12 |
| Section 6.1 | We make sure that your health information is protected | 12 |
| SECTION 7 | How other insurance works with our plan..... | 13 |
| Section 7.1 | Which plan pays first when you have other insurance?..... | 13 |

- 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 PlatinumPremier Pharmacy

Although Medicare is a Federal program, Network PlatinumPremier 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 PlatinumPremier Pharmacy PPO
Medicare Advantage Prescription Drug Plan

CoPays: IN / Out
PCP: \$0 / \$20
Specialist:\$15/\$25
ER: \$65 / \$65

<Member Name> RxBin:<003858>
RxPCN: <MD>
Member # <000000000> RxGrp: <NHPA>

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



H5215_<005>

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

Chapter 2. Important phone numbers and resources

| | | |
|------------------|--|-----------|
| SECTION 1 | Network PlatinumPremier Pharmacy contacts (how to contact us, including how to reach Customer Service at the plan) | 15 |
| SECTION 2 | Medicare (how to get help and information directly from the Federal Medicare program)..... | 22 |
| SECTION 3 | State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)..... | 24 |
| SECTION 4 | Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)..... | 24 |
| SECTION 5 | Social Security | 25 |
| SECTION 6 | Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)..... | 26 |
| SECTION 7 | Information about programs to help people pay for their prescription drugs | 27 |
| SECTION 8 | How to contact the Railroad Retirement Board | 29 |
| SECTION 9 | Do you have “group insurance” or other health insurance from an employer? | 30 |

SECTION 1 Network PlatinumPremier Pharmacy contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Network PlatinumPremier Pharmacy Customer Service. We will be happy to help you.

| Customer Service | |
|-------------------------|--|
| CALL | 1-800-378-5234 Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm. Customer Service also has free language interpreter services available for non-English speakers. |
| TTY | 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation C/O Medicare Products PO Box 120 1570 Midway Place Menasha, WI 54952 |
| WEBSITE | http://www.nppdrugsplans.com |

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions

about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*)).

You may call us if you have questions about our coverage decision process.

| Coverage Decisions for Medical Care | |
|--|--|
| CALL | 1-800-378-5234 Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| TTY | 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation C/O Medicare Products PO Box 120 1570 Midway Place Menasha, WI 54952 |

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*)).

| Appeals for Medical Care | |
|---------------------------------|--|
| CALL | 1-800-378-5234 Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| TTY | 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation C/O Medicare Appeals PO Box 120 1570 Midway Place Menasha, WI 54952 |

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If you have a problem about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Complaints about Medical Care | |
|--------------------------------------|--|
| CALL | 1-800-378-5234 Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| TTY | 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation C/O Medicare Grievances PO Box 120 1570 Midway Place Menasha, WI 54952 |

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Coverage Decisions for Part D Prescription Drugs | |
|---|---|
| CALL | 1-800-316-3107 Calls to this number are free. 24 Hours a day/7 days per week |
| TTY | 1-800-899-2114 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. |
| FAX | 1-877-837-5922 |
| WRITE | Express Scripts, Inc Attention: Prior Authorization-Part D Mail Route BL0345, 6625 West 78 th Street Bloomington, MN 55439 |

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Appeals for Part D Prescription Drugs | |
|--|--|
| CALL | 1-800-378-5234 Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| TTY | 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation C/O Medicare Appeals PO Box 120 1570 Midway Place Menasha, WI 54952 |

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

| Complaints about Part D prescription drugs | |
|---|---|
| CALL | 1-800-378-5234 Calls to this number are free. Monday through Friday, 8:00 am to 8:00 pm |
| TTY | 1-800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free Monday through Friday, 8:00 am to 8:00 pm |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation C/O Medicare Appeals PO Box 120 1570 Midway Place Menasha, WI 54952 |

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information

| Payment Requests | |
|-------------------------|--|
| CALL | 1-800-378-5234 Monday through Friday, 8:00 am to 8:00 pm Calls to this number are free. |
| TTY | 1-800-947-3529 Monday through Friday, 8:00 am to 8:00 pm This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. |
| FAX | 1-920-720-1908 |
| WRITE | Network Health Insurance Corporation Attn: Medicare Products PO Box 120 1570 Midway Place Menasha, WI 54952 |
| WEBSITE | http://www.nppdrugplans.com |

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

| Medicare | |
|-----------------|--|
| CALL | <p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p> |
| TTY | <p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> |
| WEBSITE | <p>http://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p> |

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Wisconsin, the SHIP is called The Board on Aging and Long Term Care.

The Board on Aging and Long Term Care is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

The Board on Aging and Long Term Care counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. The Board on Aging and Long Term Care counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

| The Board on Aging and Long Term Care | |
|--|---|
| CALL | 1-800-815-0015 Ombudsman Program/Volunteer Program 1-800-242-1060 Medigap Helpline |
| WRITE | 1402 Pankratz Street Suite 111 Madison, WI 53704-4001 |
| WEBSITE | http://longtermcare.wi.gov/ |

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization for each state. For Wisconsin, the Quality Improvement Organization is called MetaStar.

MetaStar has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. MetaStar is an independent organization. It is not connected with our plan.

You should contact MetaStar in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

| MetaStar | |
|-----------------|---|
| CALL | 1-800-362-2320 or 1-608-274-1940 |
| WRITE | MetaStar 2909 Landmark Place, Madison, WI 53713 |

SECTION 5 Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

| Social Security | |
|------------------------|--|
| CALL | 1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day. |

| | |
|----------------|---|
| TTY | 1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. |
| WEBSITE | http://www.ssa.gov |

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Wisconsin Medicaid.

| | |
|--|---|
| Forward Health Wisconsin Medicaid | |
| CALL | 1-800-362-3002 |
| TTY | Call 711 for TTY services. All numbers have translation services available. |
| WEBSITE | http://dhs.wisconsin.gov/medicaid |

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- To provide us Best Available Evidence (BAE) so that you are set up with correct Low Income Subsidy Level, please call Customer Service at 1-800-378-5234 or fax to Customer Service at 1-920-720-1908 Monday-Friday 8:00 am to 8:00 pm. Or you may contact Express Scripts at 1-800-316-3107, 7 days per week, 24 hours per day and they will update your Low Income Subsidy level based on Best Available Evidence Provided.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because Network PlatinumPremier Pharmacy offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to Chapter 6, Section 6 for more information about your coverage during the Coverage Gap Stage.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving “Extra Help.” A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 14% of the price for generic drugs and you pay the remaining 86% of the price. The coverage for generic drugs works differently than the 50% discount for brand name drugs. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Customer Service (phone numbers are on the back cover of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. In Wisconsin, the State Pharmaceutical Assistance Program is Wisconsin Senior Care.

| Wisconsin Senior Care | |
|------------------------------|---|
| CALL | 1-800-657-2038 |
| TTY | 1-888-701-1251 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| WRITE | Department of Health Services 1 West Wilson Street Madison, WI 53703 |
| WEBSITE | http://www.dhs.wisconsin.gov/seniorcare |

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

| Railroad Retirement Board | |
|----------------------------------|---|
| CALL | 1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays. |
| TTY | 1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free. |
| WEBSITE | http://www.rrb.gov |

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Chapter 3. Using the plan's coverage for your medical services

| | | |
|------------------|--|-----------|
| SECTION 1 | Things to know about getting your medical care covered as a member of our plan..... | 33 |
| Section 1.1 | What are “network providers” and “covered services”?..... | 33 |
| Section 1.2 | Basic rules for getting your medical care covered by the plan | 33 |
| SECTION 2 | Using network and out-of-network providers to get your medical care | 34 |
| Section 2.1 | You may choose a Primary Care Provider (PCP) to provide and oversee your medical care | 34 |
| Section 2.2 | How to get care from specialists and other network providers..... | 35 |
| Section 2.3 | How to get care from out-of-network providers | 36 |
| SECTION 3 | How to get covered services when you have an emergency or urgent need for care | 36 |
| Section 3.1 | Getting care if you have a medical emergency | 36 |
| Section 3.2 | Getting care when you have an urgent need for care..... | 38 |
| SECTION 4 | What if you are billed directly for the full cost of your covered services? | 38 |
| Section 4.1 | You can ask the plan to pay our share of the cost of your covered services..... | 38 |
| Section 4.2 | If services are not covered by our plan, you must pay the full cost..... | 39 |
| SECTION 5 | How are your medical services covered when you are in a “clinical research study”?..... | 39 |
| Section 5.1 | What is a “clinical research study”? | 39 |
| Section 5.2 | When you participate in a clinical research study, who pays for what? | 40 |
| SECTION 6 | Rules for getting care covered in a “religious non-medical health care institution” | 41 |

| | | |
|------------------|--|-----------|
| Section 6.1 | What is a religious non-medical health care institution? | 41 |
| Section 6.2 | What care from a religious non-medical health care institution is covered by our plan? | 41 |
| SECTION 7 | Rules for ownership of durable medical equipment..... | 42 |
| Section 7.1 | Will you own your durable medical equipment after making a certain number of payments under our plan?..... | 42 |

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 PlatinumPremier Pharmacy must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Network PlatinumPremier 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 or 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 PlatinumPremier 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 PlatinumPremier 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 |
|--------------------|---|

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 PlatinumPremier 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? |
|------------------|--|

| | |
|--------------------|---|
| Section 4.1 | You can ask the plan to pay our share of the cost of your covered services |
|--------------------|---|

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 |
|--------------------|--|

Network PlatinumPremier 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"? |
|------------------|---|

| | |
|--------------------|---|
| Section 5.1 | What is a "clinical research study"? |
|--------------------|---|

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

may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your provider. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Customer Service (see Chapter 2, Section 1 of this *Evidence of Coverage*).

| | |
|--------------------|--|
| Section 5.2 | When you participate in a clinical research study, who pays for what? |
|--------------------|--|

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but would be only \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other

documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”

| | |
|--------------------|---|
| Section 6.1 | What is a religious non-medical health care institution? |
|--------------------|---|

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member’s religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

| | |
|--------------------|---|
| Section 6.2 | What care from a religious non-medical health care institution is covered by our plan? |
|--------------------|---|

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

