



September 21, 2011

Dear Member,

Thank you for your membership in Network PlatinumSelect PPO

We are providing important information about the Medicare health care and prescription drug coverage we will offer next year. Please review this information to help you decide what coverage to choose for 2012. Also, please note that Medicare has changed the dates for the annual enrollment period. Starting this year, **you can make changes to your coverage from October 15 until December 7, 2011.**

Here are three documents with important information for you.

1. Please start by reading the **Annual Notice of Changes for 2012**. It gives you a summary of changes to your benefits and costs for next year. These changes will take effect on January 1, 2012.
 - **Please review this notice within a few days of receiving it** to see how the changes might affect you.
 - **If you decide to stay with Network PlatinumSelect** for 2012 – you do not have to tell us or fill out any paperwork. You will automatically stay enrolled as a member of Network PlatinumSelect.
 - **If you decide to leave Network PlatinumSelect** you can switch to a different Medicare health plan or to Original Medicare from October 15 through December 7 of 2011. The *Annual Notice of Changes* tells you more about how to do this. To learn more about your health plan options, you can visit <http://www.medicare.gov> or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
2. We're including a copy of Network PlatinumSelect's **Evidence of Coverage** for 2012. It's the legal, detailed description of your benefits and costs for 2012 if you stay enrolled as a member of Network PlatinumSelect. It also explains your rights and rules you need to follow when using your coverage for medical care and prescription drugs. Please look through this document so you know what's in it, and then keep it handy for reference.
3. We're also including a copy of the Network PlatinumSelect plan's **List of Covered Drugs (Formulary)**, effective January 1, 2012. The Drug List tells you what Part D prescription drugs are covered by the plan. It also lets you know if there are any rules that restrict coverage for a drug.

If you have questions, we're here to help. Please call Customer Service at 1-800-378-5234 (TTY only, call 1-800-947-3529). Hours are Monday through Friday 8:00 am to 8:00 pm. From October 15, 2011 through

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February 14, 2012 we are available from 8:00 am to 8:00 pm, 7 days a week. Calls to these numbers are free. Customer Service has free language interpreter services available for non-English speakers. You can also visit our website, (www.nppdrugplans.com).

We value your membership and hope to continue to serve you next year.

Sincerely,

A handwritten signature in cursive script that reads "Marcia Broeren RN".

Marcia Broeren, RN, BSN
Vice President, Medicare Products
Network Health Insurance Corporation

A Medicare Advantage PPO Plan with a Medicare Contract



Network PlatinumSelect PPO Annual Notice of Changes for 2012

This booklet tells you how your benefits and costs will change next year if you stay in Network PlatinumSelect. These changes will take effect on January 1, 2012 if you stay in this plan.

To decide what's best for you, compare this information with the benefits and costs of other Medicare health plans in your area, as well as the benefits and costs of Original Medicare.

This plan, Network PlatinumSelect, is offered by Network Health Insurance Corporation. (When this *Annual Notice of Changes* says "we," "us," or "our," it means Network Health Insurance Corporation. When it says "plan" or "our plan," it means Network PlatinumSelect.)

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

This information is available in an alternate format, including large print, Braille, or audio. Please call Customer Service at the number listed in the back of this booklet if you need plan information in another format or language.

Annual Notice of Changes for 2012

Table of Contents

Section 1. Important things to know.....	1
The Annual Enrollment Period ends on December 7 th	1
You are currently enrolled in Network Platinum <i>Select</i> , which is a Medicare PPO	1
If you stay enrolled in Network Platinum <i>Select</i> for 2012, there will be some changes to your benefits and to what you pay	1
This <i>Annual Notice of Changes</i> is only a summary (see your <i>Evidence of Coverage</i> for the details)	1
What should you do?	2
There are programs to help people with limited resources pay for their prescription drugs.....	2
What if you are currently getting help to pay for your drugs?.....	3
Section 2. Changes to your monthly premium	3
Section 3. Medical services: Changes to your benefits and cost sharing (“out-of-pocket” costs).....	4
Changes to your <u>benefits</u>	4
Changes to your cost sharing (“ <u>out-of-pocket</u> ” costs)	5
Section 4. Part D prescription drugs: Changes to your benefits and “out-of- pocket” costs	11
Changes to the <i>List of Covered Drugs (Formulary)</i>	11
Changes to your “ <u>out-of-pocket</u> ” costs	11
What if changes for 2012 affect drugs you are taking now?	13
Section 5. What about changes to the plan’s network of providers?	14
Will your doctors and other providers still be in the plan’s network next year?	14
Section 6. Do you want to stay in the plan or make a change?	14

Do you want to stay with Network Platinum*Select*?14

Do you want to make a change?14

Section 7. Do you need some help? Would you like more information? 16

We have information and answers for you16

You can get help and information from your State Health Insurance Assistance
Program (SHIP)16

You can get help and information from Medicare.....16

Section 1. Important things to know

The Annual Enrollment Period ends on December 7th

Starting this year, you have from October 15 **until December 7 to make a change** to your Medicare coverage.

You are currently enrolled in Network PlatinumSelect which is a Medicare PPO

You are currently enrolled as a member of Network PlatinumSelect. This plan is a Medicare Advantage PPO (PPO stands for Preferred Provider Organization). Like all Medicare Advantage Plans, this Medicare PPO is approved by Medicare and run by a private company. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

If you stay enrolled in Network PlatinumSelect for 2012, there will be some changes to your benefits and to what you pay

Each year, Medicare health plans may decide to change the premiums, cost-sharing amounts, and benefits they offer. These changes may include increasing or decreasing premiums, increasing or decreasing cost-sharing amounts, and adding or subtracting benefits.

We're sending you this *Annual Notice of Changes* to tell you how your benefits and costs as a member of Network PlatinumSelect will change next year from your current benefits. The changes will take effect on January 1, 2012. Medicare has approved these changes.

This Annual Notice of Changes is only a summary (see your Evidence of Coverage for the details)

This *Annual Notice of Changes* gives you a summary of the changes in your benefits and what you will pay for these services in 2012. This notice is a brief summary, not a comprehensive description of benefits. For more information, contact the plan or look in your *Evidence of Coverage*.

- To get the details, you can look in the 2012 *Evidence of Coverage* for Network PlatinumSelect. The *Evidence of Coverage* is the legal, detailed description of your benefits and costs for 2012. It explains your rights and the rules you need to follow to get your covered services and prescription drugs. (We have included a copy of the *Evidence of Coverage* in the same envelope with this *Annual Notice of Changes*. If you do not have this copy, please call Customer Service.)
- If you have questions or need more information, you can always call Customer Service at 1-800-378-5234 (TTY only, call 1-800-947-3529). Hours are 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. Calls to these numbers are free.

What should you do?

We want you to know what's ahead for next year, so **please read the rest of this document very soon to see how the changes in benefits and costs will affect you if you stay enrolled in Network PlatinumSelect for 2012.** Starting this year, **you have only until December 7 to make a change** to your Medicare coverage. If you make a change, your new coverage will start on January 1, 2012.

To decide what's best for you, compare this information about the 2012 benefits and costs for Network PlatinumSelect to what your benefits and costs would be if you switched to a different Medicare health plan or to Original Medicare.

If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website at <http://www.medicare.gov>. The Plan Finder helps you compare your choices by giving you information about plans' benefits and costs and showing you how Medicare rates the plans. For example, these ratings let you compare how well plans are doing in different categories that include detecting and preventing illness, member satisfaction, and customer service. (To view the information about plans, go to <http://www.medicare.gov>. Click on the "Health & Drug Plans" button on the left and then choose "Compare Drug and Health Plans.") If you want us to mail you a copy of the ratings for Network PlatinumSelect that are shown on the Medicare website, please call us at 1-800-378-5234, (TTY users call 1-800-947-3529). Monday through Friday, 8:00 am to 8:00 pm.

To get information about Original Medicare and about Medicare plans available in your area, you can also call Medicare or your State Health Insurance Assistance Program. For numbers to call, see Section 7 of this *Annual Notice of Changes*.

We value your membership in Network PlatinumSelect and hope to keep you as a member. But if you want to make a change for 2012, see "*When can you change to a different plan?*" in Section 6 for time periods when you can make a change.

There are programs to help people with limited resources pay for their prescription drugs

You might qualify to get help in paying for your drugs. There *are two* basic kinds of help:

- **"Extra Help" from Medicare.** This program is also called the "low-income subsidy" or LIS. If your yearly income and resources are below certain limits, you may qualify for this help. To learn more about the Extra Help program, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. You can also look in Section III of the *Medicare & You 2012 Handbook* or call your State Health Insurance Assistance Program (the name and phone numbers for this organization are on the back cover of this booklet).
- **Help from your state's pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription

drugs based on financial need, age, or medical condition. In Wisconsin the program is called Wisconsin Senior Care. Each state has different rules. To learn more about the program in your state, check with your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*).

What if you are currently getting help to pay for your drugs?

If you already get help paying for your drugs, **some of the information about premiums and Part D drug costs in this *Annual Notice of Changes* is not correct for you.** We will send you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover of this booklet.

Section 2. Changes to your monthly premium

	2011 (this year)	2012 (next year)
Monthly premium	\$0	\$0
	(You must continue to pay your Medicare Part B premium.)	(You must continue to pay your Medicare Part B premium.)

Exceptions:

- If you are required to pay a late enrollment penalty (because you went at least 63 days without Part D or other “creditable” prescription drug coverage anytime after the end of your Part D initial enrollment period), your monthly premium for 2012 will be \$0 *plus* the amount of your late enrollment penalty. For more information about this penalty, see Chapter 6 of your *Evidence of Coverage*.
- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, go to Chapter 6, Section 11 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should

call 1-877-486-2048. Or you may call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Section 3. Medical services: Changes to your benefits and cost sharing (“out-of-pocket” costs)

Changes to your benefits

As shown below, Network PlatinumSelect is changing our covered benefits for next year. For details, see Chapters 3 and 4 in your *Evidence of Coverage*.

	2011 (this year)	2012 (next year)
<i>Supplemental annual routine physical exam</i>	<p>Covered up to 1 annual routine physical exam.</p> <p>Includes lipid profile, complete blood count and glucose monitoring</p>	<p>Starting in 2011 you are entitled to a Annual Medicare Wellness visit with your primary care doctor.</p> <p>In 2012 the Lipid profile, Complete blood count and Fasting Blood sugar test will be part of that Annual Medicare Wellness visit.</p> <p>We will no longer offer the supplemental annual routine exam.</p>
Inpatient Hospital-Acute	<p>In-Network \$175 copay per day: days 1-7, of total inpatient hospital stay.</p> <p>Out-of-Network \$215 copay per day: days 1-7, of total inpatient hospital stay.</p>	<p>In-Network \$175 copay per day: days 1-10, of total inpatient hospital stay.</p> <p>Out-of-Network \$215 copay applies to: Days 1-10 of total inpatient hospital stay.</p>
Inpatient Hospital-Psychiatric	<p>In-Network \$175 copay per day:</p>	<p>In-Network \$175 copay per day:</p>

	2011 (this year)	2012 (next year)
	<p>days 1-7, of total inpatient stay.</p> <p>Out-of-Network \$300 copay per day: days 1-7, of total inpatient stay.</p>	<p>days 1-10, of total inpatient stay.</p> <p>Out-of-Network \$300 copay per day: days 1-10, of total inpatient stay.</p>
Health and Wellness Education Program	Was not included last year	<p>In-Network</p> <p>\$0 for Medicare covered health and wellness services.</p> <p>\$3.00 per visit, up to 12 visits or \$36.00 a month maximum benefit reimbursement for health club/fitness facility membership.</p> <p>Out-of-Network</p> <p>50% of the cost for covered health and wellness services.</p> <p>\$3.00 per visit, up to 6 visits or \$18.00 a month maximum benefit reimbursement for health club/fitness facility membership.</p>

Changes to your cost sharing (“out-of-pocket” costs)

Cost sharing is your share of the cost of covered medical services. It is the amount you pay “out-of-pocket” for coinsurance, and copayments. You usually pay these amounts at the time services are received. The chart below summarizes changes from 2011 to 2012 to your “out-of-pocket” costs. For details, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *Evidence of Coverage*.

	2011 (this year)	2012 (next year)
<p>Maximum out-of-pocket amount for <u>in-network</u> medical services</p> <p>The in-network maximum out-of-pocket amount is the most that you pay for copayments and coinsurance during the calendar year for covered Part A and Part B services received from in-network providers.</p> <p>Amounts you pay for your copayments and coinsurance for services from network providers count toward your in-network maximum out-of-pocket amount.</p> <p>Amounts you pay for prescription drugs and services from out-of-network providers do <u>not</u> count toward your in-network maximum out-of-pocket amount.</p>	<p>\$2900</p> <p>This is the most you pay out-of-pocket for covered Part A and Part B services from <u>in-network</u> providers.</p> <p>Once you have paid out-of-pocket for covered in-network Part A and Part B services, you pay nothing for your covered in-network Part A and Part B services for the rest of the calendar year.</p>	<p>\$2900</p> <p>This is the most you pay out-of-pocket for covered Part A and Part B services from <u>in-network</u> providers.</p> <p>Once you have paid out-of-pocket for covered in-network Part A and Part B services, you pay nothing for your covered in-network Part A and Part B services for the rest of the calendar year.</p>

	2011 (this year)	2012 (next year)
<p>Maximum out-of-pocket amount for <u>both in-network and out-of-network</u> medical services</p> <p>The maximum out-of-pocket amount for both in-network and out-of-network services is also called the combined maximum out-of-pocket amount. This is the most you pay for copayments and coinsurance during the calendar year for covered Part A and Part B services received from both in-network and out-of-network providers.</p> <p>Amounts you pay for your copayments and coinsurance count toward your combined maximum out-of-pocket amount. Amounts you pay for your plan premium and for your prescription drugs do <u>not</u> count toward your combined maximum out-of-pocket amount.</p>	<p>\$2900</p> <p>This is the most you pay out-of-pocket for covered Part A and Part B services from <u>both in-network and out-of-network</u> providers.</p> <p>Once you have paid \$2900 out-of-pocket for covered Part A and Part B services, you pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p>	<p>\$2900</p> <p>This is the most you pay out-of-pocket for covered Part A and Part B services from <u>both in-network and out-of-network</u> providers.</p> <p>Once you have paid \$2900 out-of-pocket for covered Part A and Part B services, you pay nothing for your covered Part A and Part B services for the rest of the calendar year.</p>
<p>Cardiac and Pulmonary Rehabilitation Services</p>	<p>Out-of-Network \$55 copay for Cardiac Rehabilitation</p>	<p>Out-of-Network \$40 copay for Cardiac Rehabilitation</p>
<p>Emergency Care</p>	<p>In-Network \$50 copay each Medicare covered emergency room visit.</p> <p>Out-of-Network \$50 copay each Medicare covered emergency room visit in the U.S.</p>	<p>In-Network \$65 copay each Medicare covered emergency room visit.</p> <p>Out-of-Network \$65 copay each Medicare covered emergency room visit in the U.S.</p>

	2011 (this year)	2012 (next year)
Home Health Services	<p>In-Network \$10 copay for Medicare covered home health services.</p> <p>Out-of-Network \$40 copay for Medicare covered home health services.</p>	<p>In-Network \$0 copay for Medicare covered home health services.</p> <p>Out-of-Network 30% of the cost for Medicare covered home health services.</p>
Primary Care Physician Services (PCP)	<p>Out-of-Network \$35 copay each PCP visit</p>	<p>Out-of-Network \$20 copay each PCP Visit</p>
Chiropractic Services	<p>In-Network \$30 copay each Medicare covered visit</p> <p>Out-of-Network \$55 copay each Medicare covered visit</p>	<p>In-Network \$20 copay each Medicare Covered visit</p> <p>Out-of-Network \$45 copay each Medicare covered visit.</p>
Occupational Therapy	<p>Out-of-Network \$55 copay each Medicare covered occupational therapy visit</p>	<p>Out-of-Network \$35 copay each Medicare covered occupational therapy visit.</p>
Physician Specialist Services	<p>Out-of-Network \$55 copay each specialist visit for Medicare covered services</p>	<p>Out-of-Network \$35 copay each Specialist visit for Medicare covered services.</p>
Mental Health Specialty Services	<p>Out-of-Network \$40 copay each Medicare covered visit</p>	<p>Out-of-Network \$45 copay each Medicare covered visit</p>
Podiatry Services	<p>Out-of-Network \$55 copay each Medicare covered visit</p>	<p>Out-of-Network \$35 copay each Medicare covered visit.</p>

	2011 (this year)	2012 (next year)
Other Health Care Professional	Out-of-Network \$55 copay each Medicare covered visit	Out-of-Network \$35 copay each Medicare covered visit.
Psychiatric Services	Out-of-Network \$40 copay each Medicare covered visit.	Out-of-Network \$45 copay each Medicare covered visit.
Physical Therapy & Speech Pathology Services	Out-of-Network \$55 copay each Medicare covered physical therapy and/or speech/language therapy visit.	Out-of-Network \$35 copay each Medicare covered physical therapy and/or occupational therapy visit.
Outpatient Diagnostic Procedures/Tests/Lab Services	Out-of-Network \$25 copay each Medicare covered clinical/diagnostic test/lab service	Out-of-Network \$20 copay each Medicare covered clinical/diagnostic test/lab service
Outpatient Diagnostic/Therapeutic Radiology Services	In-Network 5% coinsurance each Medicare covered x-ray and/or radiation therapy service. Out-of-Network 10% coinsurance each Medicare covered x-ray and/or radiation therapy service	In-Network \$20 copay each Medicare covered x-ray. 20% coinsurance each Medicare covered radiation therapy service Out-of-Network 30% coinsurance each Medicare covered x-ray and/or radiation therapy service
Outpatient Hospital Services	In-Network \$100 copay each outpatient hospital visit	In-Network \$115 copay each outpatient hospital visit
Ambulatory Surgical Center (ASC) Services	In-Network \$100 copay each visit to an ASC	In-Network \$115 copay each visit to an ASC

	2011 (this year)	2012 (next year)
Outpatient Substance Abuse	Out-of-Network \$55 copay each visit	Out-of-Network \$45 copay each visit.
Outpatient Blood Services	Out-of-Network \$50 copay each Medicare covered service.	Out-of-Network \$40 copay each Medicare covered service.
Ambulance Services	In-Network \$75 copay for Medicare covered ambulance services Out-of-Network \$75 copay for Medicare covered ambulance services	In-Network \$95 copay for Medicare covered ambulance services Out-of-Network \$95 copay for Medicare covered ambulance services
Diabetic Supplies and Services	Out-of-Network \$50 copay each 90 day supply of Diabetic Supply item.	Out-of-Network \$40 copay each 90 supply of Diabetic Supply item
End-Stage Renal Disease (ESRD)	Out-of-Network \$50 copay each visit	Out-of-Network \$40 copay each visit
Comprehensive Dental	Out-of-Network \$55 copay each Medicare covered visit	Out-of-Network \$45 copay each Medicare covered visit
Eye Exams	Out-of-Network \$55 copay for Medicare covered eye exams.	Out-of-Network \$45 copay for Medicare covered eye exams.
Eye Wear	Out-of-Network \$55 copay for Medicare covered eyewear.	Out-of-Network \$45 copay for Medicare covered eyewear
Hearing Exams	Out-of-Network \$55 copay for Medicare covered hearing exams.	Out-of-Network \$45 copay for Medicare covered hearing exams.

Section 4. Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

Changes to the *List of Covered Drugs (Formulary)*

Network PlatinumSelect has a “*List of Covered Drugs (Formulary)*” – or “Drug List” for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1.1 of your *Evidence of Coverage* explains about Part D drugs.)

We may make changes to the plan’s Drug List from time to time throughout the year. In addition, there are a number of changes to the Drug List that will take effect on January 1, 2012. Changes to the plan’s Drug List have been approved by Medicare.

- **We have added some new drugs to the list and removed others.** We have added some new drugs that became available. We have replaced some expensive drugs with less costly drugs that have been shown to work just as well or better.
- **We have added some new restrictions to certain drugs, and reduced the restrictions on others.** Restrictions can include a requirement to get plan approval in advance or to try a different drug first to see how well it works. Restrictions can also include limits on the quantity of the drug that the plan will cover for you.
 - If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug.

Please check to see if any of these changes to drug coverage affect the drugs you use.

- You can look for your drugs on the Drug List we sent with this *Annual Notice of Changes*.
- The Drug List we sent includes many of the drugs that we cover, but it does not include all of our covered drugs. If you can’t find some of your drugs on this Drug List, you may find them on a complete Drug List, which includes all the drugs we cover. You can get the complete Drug List by calling Customer Service or visiting our website (<http://www.nppdrugplans.com/>).

Changes to your “out-of-pocket” costs

Every drug on the plan’s Drug List is in one of four (4) cost-sharing tiers. Medicare allows us to **change what you pay for a drug in each cost-sharing tier** only once a year. The changes shown below will take effect on January 1, 2012, and stay the same for the entire plan year.

Besides the changes to copayments and coinsurance you see below, there is another change that could affect what you pay for your drugs next year. **We have moved some of the drugs on the Drug List to a different cost-sharing tier.** Some drugs will be in a lower cost-sharing

tier, others will be in a higher cost-sharing tier. To see if any of your drugs have been moved to a different cost-sharing tier, look them up on the Drug List.

Changes to what you pay for your drugs during the Initial Coverage Stage

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount).

The copayment and coinsurance amounts you pay for covered drugs will be exactly the same in 2012 as they are in 2011.

Changes to the plan's Drug Payment Stages

The chart below summarizes changes to the plan's Drug Payment Stages. These changes affect Part D prescription drugs only.

	2011 (this year)	2012 (next year)
Initial Coverage Stage	\$2840	\$2930
During the Initial Coverage Stage, the plan pays its share of the cost of your covered drugs, and you pay your share.	When the total costs for your Part D drugs reaches this amount, you move on the Coverage Gap Stage.	When the total costs for your Part D drugs reaches this amount, you move on the Coverage Gap Stage.
You stay in this stage until your year-to-date "total drug costs" total \$2930. Once you reach this limit, you move on to the Coverage Gap Stage.		

	2011 (this year)	2012 (next year)
<p>Coverage Gap Stage</p> <p>During the Coverage Gap Stage, you pay only a certain percent of the costs for your generic drugs, and receive a discount on your brand name drugs.</p> <p>You stay in the Coverage Gap Stage until your out-of-pocket costs for your Part D drugs reaches the amount that qualifies you for Catastrophic Coverage.</p>	<p>During the Coverage Gap Stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 93% of the price for generic drugs.</p> <p>You stay in this stage until your out-of-pocket costs reach:</p> <p>\$4550</p> <p>This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.</p>	<p>During the Coverage Gap Stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 86% of the price for generic drugs.</p> <p>You stay in this stage until your out-of-pocket costs reach:</p> <p>\$4700</p> <p>This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.</p>
<p>Catastrophic Coverage Stage</p> <p>During the Catastrophic Coverage Stage, the plan will pay most of the cost for your Part D drugs.</p> <p>You will stay in this stage until the end of the calendar year.</p>	<p>\$2.50 or 5% for generic drugs and \$6.30 or 5% for brand drugs whichever is greater.</p>	<p>\$2.60, or 5% for generic drugs, and \$6.50, or 5% for brand drugs, whichever is greater.</p>

What if changes for 2012 affect drugs you are taking now?

What if a drug you are taking now is not on the Drug List for 2012? What if it has been moved to a higher cost-sharing tier? What if a new restriction has been added to the coverage for this drug? If you are in any of these situations, here’s what you can do:

- In some situations, the plan will cover a **one-time, temporary supply** of your drug when your current supply runs out. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. Chapter 5, Section 6.2 of the

Evidence of Coverage explains when you can get a temporary supply and how to ask for one.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this *Annual Notice of Changes*. Look for Chapter 9 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

Section 5. What about changes to the plan's network of providers?

Will your doctors and other providers still be in the plan's network next year?

There are changes to the network of providers for 2012. In addition, it's possible for the network of plan providers to change at any time during the year.

- **Please check with your doctors and other providers you currently use** to make sure they will continue to be part of the provider network for Network PlatinumSelect in 2012.
- For the most up-to-date information on the network of providers, check our website (<http://www.nppdrugplans.com/>) or call Customer Service (see phone numbers on the back cover of this booklet).

Section 6. Do you want to stay in the plan or make a change?

Do you want to stay with Network PlatinumSelect?

If you want to keep your membership in Network PlatinumSelect for 2012, it's easy. You don't need to tell us or fill out any paperwork. **You will automatically remain enrolled as a member if you do not sign up for a different plan or Original Medicare.**

Do you want to make a change?

If you decide to leave Network PlatinumSelect, you can switch to a different Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan).

If you want to change to a different plan, there are many choices. If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on the “Health & Drug Plans” button on the left. Then choose “Compare Drug and Health Plans.”) You can also get information about plans from Medicare or from your State Health Insurance Assistance Program. (For numbers to call, see Section 7 of this *Annual Notice of Changes*.) As a reminder, Network Health Insurance Corporation offers other Medicare health plans in addition to the plan you are now enrolled in. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

When can you change to a different plan?

- During the **yearly enrollment period (called the “annual coordinated election period”) from October 15 through December 7, 2011**, you can change to another Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan). Your new coverage will begin on January 1, 2012.
- You also have **another, more limited enrollment period from January 1 through February 14, 2012**. During this period (called the annual “Medicare Advantage Disenrollment Period”), you could switch from Network Platinum *Select* to Original Medicare. Your coverage will begin the first day of the month after we get your request to switch to Original Medicare.
 - If you choose to switch to Original Medicare during this annual disenrollment period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage. Your drug coverage will begin the first day of the month after the drug plan gets your enrollment form.
 - For more information about your choices during the January 1 through February 14 annual disenrollment period, please see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

Are these the only times of the year to choose a different plan?

For most people, yes. Certain individuals, such as those with Medicaid, those who get Extra Help paying for their drugs, or those who move out of the service area, can make changes at other times. There may be other situations in which you are allowed to change plans. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

How do you make a change?

See Chapter 10 of the *Evidence of Coverage*. It tells what you need to do to make a change from Network Health Insurance Corporation to another plan.

Check on these things before you make a change

- **Are you a member of an employer or retiree group plan?** If you are, please check with the benefits administrator of your employer or retiree group *before you change your plan*.

This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

- **Are you getting help with paying for your drugs from a State Pharmaceutical Assistance Program (SPAP)?** If you are, please check with this program before switching to another plan. The phone number for your State Pharmaceutical Assistance Program is listed in Chapter 2, Section 7 of the *Evidence of Coverage*.

Section 7. Do you need some help? Would you like more information?

We have information and answers for you

To learn more, read the information we sent in the same package with this *Annual Notice of Changes*. This includes a copy of the *Evidence of Coverage* and a copy of the *List of Covered Drugs (Formulary)*.

If you have any questions, we are here to help. Please call our Customer Service at 1-800-378-5234 (TTY only, call 1-800-947-3529). We are available for phone calls Monday through Friday, 8:00 am to 8:00 pm. Calls to these numbers are free.

You can get help and information from your State Health Insurance Assistance Program (SHIP)

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 plan choices and answer questions about switching plans. You can call The Board on Aging and Long Term Care at 1-800-242-1060 or 1-608-267-3201. You can learn more about The Board on Aging and Long Term Care by visiting their website (<http://longtermcare.wi.gov/>).

You can get help and information from Medicare

Here are three ways to get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Visit the Medicare website** (<http://www.medicare.gov>).

- **Read *Medicare & You 2012*.** Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) 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.



Network PlatinumSelect Customer Service

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

The Board on Aging and Long Term Care

The Board on Aging and Long Term Care is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

