

**Introduction to the Summary of Benefits Report
for NETWORK PLATINUM MEDICARE ADVANTAGE PLANS (PPO)
January 1, 2010 - December 31, 2010
EAST CENTRAL WISCONSIN**

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

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like a Network Platinum Medicare Advantage plan. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call Network Health Insurance Corporation at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

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

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

WHERE ARE NETWORK PLATINUM MEDICARE PLANS AVAILABLE?

There is more than one plan listed in this Summary of Benefits. If you are enrolled in one plan and wish to switch to another plan, you may do so only during certain times of the year. Please call Customer Service for more information. The service area for these plans includes: Brown, Calumet, Dodge, Fond du Lac, Green Lake, Manitowoc, Marquette, Outagamie, Portage, Sheboygan, Waupaca, Waushara, Winnebago counties, WI. You must live in one of these areas to join a plan.

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WHO IS ELIGIBLE TO JOIN A NETWORK PLATINUM MEDICARE PLAN?

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

CAN I CHOOSE MY DOCTORS?

Network Health Insurance Corporation has formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list visit us at www.nppdrugplans.com. Our customer service number is listed at the end of this introduction.

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

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

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

Network Platinum*Plus* (PPO) and Network Platinum*Premier* (PPO) do cover Medicare Part B prescription drugs. Network Platinum*Plus* (PPO) and Network Platinum*Premier* (PPO) do NOT cover Medicare Part D prescription drugs.

Network Platinum*Plus* Pharmacy (PPO), Network Platinum*Premier* Pharmacy (PPO), and Network Platinum*Select* (PPO) cover Medicare Part B prescription drugs AND Medicare Part D prescription drugs.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN A PLAN WITH MEDICARE PART D PRESCRIPTION COVERAGE?

Network Platinum*Plus* Pharmacy (PPO), Network Platinum*Premier* Pharmacy (PPO), and Network Platinum*Select* (PPO) have formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Directory or visit us at <http://www.nppdrugplans.com/locator30/>. Our customer service number is listed at the end of this introduction.

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WHAT IS A PRESCRIPTION DRUG FORMULARY?

Network Platinum*Plus* Pharmacy (PPO), Network Platinum*Premier* Pharmacy (PPO), and Network Platinum*Select* (PPO) use a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at <http://www.nppdrugplans.com/cgi-bin/formulary-2009/index.pl>

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

HOW CAN I GET EXTRA HELP WITH PRESCRIPTION DRUG PLAN COSTS?

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/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Network Platinum*Plus* (PPO), Network Platinum*Plus* Pharmacy (PPO), Network Platinum*Premier* (PPO), Network Platinum*Premier* Pharmacy (PPO), or Network Platinum*Select* (PPO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe

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that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, which is MetaStar at 1-800-362-2320 or 608-274-1940 or email address is benehotline@metastar.com

As a member of Network Platinum*Plus* Pharmacy (PPO), Network Platinum*Premier* Pharmacy (PPO), or Network Platinum*Select* (PPO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, MetaStar at 1-800-362-2320.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

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

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

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Network Health Insurance Corporation for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin alpha or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

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- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and infusion drugs provided through DME.

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customers service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plan" or "Compare Health Plans and Medigap Policies in Your Area" to compare plan rating for Medicare plans in your area. You can also call us directly at 1-800-378-5234 to obtain a copy of the plan ratings for this plan. TTY users call 1-800-947-3529.

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

Visit us at www.nppdrugplans.com or, call us:

Customer Service Hours

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

Current members should call:

locally (920)-720-1345 or toll-free (800)-378-5234
for questions related to the Medicare Advantage program
and/or the Medicare Part D Prescription Drug program.
(TTY/TDD (800)-947-3529)

Prospective members should call:

locally (920)-720-1280 or toll-free (800)-983-7587
for questions related to the Medicare Advantage program
and/or the Medicare Part D Prescription Drug program.
(TTY/TDD (800)-947-3529)

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

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

You can call 24 hours a day, 7 days a week.

Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
IMPORTANT INFORMATION		
<p>1 - Premium and Other Important Information</p>	<p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p>	<p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In and Out-of-Network \$2,900 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>In-Network Supplemental Services: - Vision Services - Health/Wellness Education</p> <p>Out-of-Network Supplemental Services: - Vision Services - Health/Wellness Education</p>
<p>2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>Out-of-Network You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.</p> <p>Plan covers you when you travel in the U.S.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>General \$28 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In and Out-of-Network \$2,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>In-Network: Supplemental Services: - Vision Services - Health/Wellness Education</p> <p>Out-of-Network: Supplemental Services: - Vision Services - Health/Wellness Education</p>	<p>General \$62 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>In and Out-of-Network \$2,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services:</p> <p>In-Network: Supplemental Services: - Vision Services - Health/Wellness Education</p> <p>Out-of-Network: Supplemental Services: - Vision Services - Health/Wellness Education</p>	<p>General \$66 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Out-of-Network \$1,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services: Supplemental Services: - Hearing Services - Vision Services - Health/Wellness Education</p>	<p>General \$115 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Out-of-Network \$1,000 out-of-pocket limit.</p> <p>There is no limit on cost sharing for the following services: Supplemental Services: - Hearing Services - Vision Services - Health/Wellness Education</p>
<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>Out-of-Network You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.</p> <p>Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>Out-of-Network You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.</p> <p>Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>Out-of-Network You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.</p> <p>Plan covers you when you travel in the U.S.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals.</p> <p>Out-of-Network You will pay less if you get prior authorization or let the plan know before you get an out-of-network benefit.</p> <p>Plan covers you when you travel in the U.S.</p>

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SUMMARY OF BENEFITS		
INPATIENT CARE		
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2009 the amounts for each benefit period were: Days 1 - 60: \$1068 deductible Days 61 - 90: \$267 per day Days 91 - 150: \$534 per lifetime reserve day.</p> <p>These amounts will change for 2010.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>In-Network For Medicare-covered hospital stays: Days 1 - 4: \$150 copay per day.</p> <p>Days 5 - 90: \$0 copay per day.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays: Days 1 - 7: \$200 copay per day.</p> <p>Days 8 and beyond: \$0 copay per day.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network \$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>Out-of-Network For hospital stays: Days 1 - 7: \$75 copay per day.</p> <p>Days 8 and beyond: \$0 copay per day.</p>	<p>Out-of-Network For hospital stays: Days 1 - 7: \$75 copay per day.</p> <p>Days 8 and beyond: \$0 copay per day.</p>	<p>Out-of-Network For hospital stays: Days 1 - 7: \$75 copay per day.</p> <p>Days 8 and beyond: \$0 copay per day.</p>	<p>Out-of-Network For hospital stays: Days 1 - 7: \$75 copay per day.</p> <p>Days 8 and beyond: \$0 copay per day.</p>

Summary of Benefits Report

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4 - Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above). 190 day lifetime limit in a Psychiatric Hospital.	<p>In-Network For Medicare-covered hospital stays: Days 1 - 5: \$175 copay per day.</p> <p>Days 6 - 90: \$0 copay per day.</p> <p>Plan covers 60 lifetime reserve days. Cost per lifetime reserve day: Days 1 - 5: \$0 copay per day.</p> <p>Days 6 - 60: \$0 copay per day.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network For hospital stays: Days 1 - 7: \$300 copay per day.</p> <p>Days 8 - 190: \$0 copay per day.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>	<p>In-Network \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>Out-of-Network For hospital stays: Days 1 - 7: \$125 copay per day.</p> <p>Days 8 - 190: \$0 copay per day.</p>	<p>Out-of-Network For hospital stays: Days 1 - 7: \$125 copay per day.</p> <p>Days 8 - 190: \$0 copay per day.</p>	<p>Out-of-Network For hospital stays: Days 1 - 7: \$125 copay per day.</p> <p>Days 8 - 190: \$0 copay per day.</p>	<p>Out-of-Network For hospital stays: Days 1 - 7: \$125 copay per day.</p> <p>Days 8 - 190: \$0 copay per day.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
<p>5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: \$0 per day Days 21 - 100: \$133.50 per day</p> <p>These amounts will change for 2010.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For SNF stays: Days 1 - 100: \$30 copay per day.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>1 day prior hospital stay is required.</p> <p>Out-of-Network \$70 per SNF day.</p>
<p>6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 copay for each Medicare-covered home health visit.</p> <p>Out-of-Network \$25 copay for home health visits.</p>
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for SNF services.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network \$50 per SNF day.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for SNF services.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network \$50 per SNF day.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for SNF services.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network \$25 per SNF day.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for SNF services.</p> <p>Plan covers up to 100 days each benefit period.</p> <p>1 day prior hospital stay is required.</p> <p>Out-of-Network \$25 per SNF day.</p>
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p> <p>Out-of-Network \$15 copay for home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p> <p>Out-of-Network \$15 copay for home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p> <p>Out-of-Network \$15 copay for home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p> <p>Out-of-Network \$15 copay for home health visits.</p>
<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

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OUTPATIENT CARE		
8 - Doctor Office Visits	20% coinsurance	<p>General See “Physical Exams,” for more information.</p> <p>In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$30 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$20 copay for each primary care doctor visit.</p> <p>\$40 copay for each specialist visit.</p>
9 - Chiropractic Services	<p>Routine care not covered</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>In-Network \$30 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$40 copay for chiropractic benefits.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>General See “Physical Exams,” for more information.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$10 copay for each in- area, network urgent care Medicare-covered visit.</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$10 copay for each primary care doctor visit.</p> <p>\$20 copay for each specialist visit.</p>	<p>General See “Physical Exams,” for more information.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$10 copay for each in- area, network urgent care Medicare-covered visit.</p> <p>\$15 copay for each specialist visit for Medicare-covered benefits.</p> <p>Out-of-Network \$10 copay for each primary care doctor visit.</p> <p>\$20 copay for each specialist visit.</p>	<p>General See “Physical Exams,” for more information.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for the cost of each in-area, network urgent care Medicare- covered visit.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p> <p>Out-of-Network \$5 copay for each primary care doctor visit.</p> <p>\$10 copay for each specialist visit.</p>	<p>General See “Physical Exams,” for more information.</p> <p>In-Network \$0 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$0 copay for the cost of each in-area, network urgent care Medicare- covered visit.</p> <p>\$0 copay for each specialist doctor visit for Medicare-covered benefits.</p> <p>Out-of-Network \$5 copay for each primary care doctor visit.</p> <p>\$10 copay for each specialist visit.</p>
<p>In-Network \$15 copay for each Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$20 copay for chiropractic benefits.</p>	<p>In-Network \$15 copay for Medicare- covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$20 copay for chiropractic benefits.</p>	<p>In-Network \$0 copay for Medicare- covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$10 copay for chiropractic benefits.</p>	<p>In-Network \$0 copay for Medicare- covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> <p>Out-of-Network \$10 copay for chiropractic benefits.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
10 - Podiatry Services	<p>Routine care not covered</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network \$40 copay for podiatry benefits.</p>
11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual or group therapy visit.</p> <p>Out-of-Network \$40 copay for Mental Health benefits.</p> <p>\$40 copay for Mental Health benefits with a psychiatrist.</p>
12 - Outpatient Substance Abuse Care	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual or group visits.</p> <p>Out-of-Network \$40 copay for outpatient substance abuse benefits.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$15 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$0 copay for Medicare-covered podiatry benefits.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>	<p>In-Network \$0 copay for Medicare-covered podiatry benefits.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
<p>Out-of-Network \$20 copay for podiatry benefits.</p>	<p>Out-of-Network \$20 copay for podiatry benefits.</p>	<p>Out-of-Network \$10 copay for podiatry benefits.</p>	<p>Out-of-Network \$10 copay for podiatry benefits.</p>
<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>
<p>In-Network \$15 copay for each Medicare-covered individual or group therapy visit.</p>	<p>In-Network \$15 copay for each Medicare-covered individual or group therapy visit.</p>	<p>In-Network \$0 copay for Medicare-covered Mental Health visits.</p>	<p>In-Network \$0 copay for Medicare-covered Mental Health visits.</p>
<p>Out-of-Network \$20 copay for Mental Health benefits.</p> <p>\$20 copay for Mental Health benefits with a psychiatrist.</p>	<p>Out-of-Network \$20 copay for Mental Health benefits.</p> <p>\$20 copay for Mental Health benefits with a psychiatrist.</p>	<p>Out-of-Network \$10 copay for Mental Health benefits.</p> <p>\$10 copay for Mental Health benefits with a psychiatrist.</p>	<p>Out-of-Network \$10 copay for Mental Health benefits.</p> <p>\$10 copay for Mental Health benefits with a psychiatrist.</p>
<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>
<p>In-Network \$10 copay for Medicare-covered individual or group visits.</p>	<p>In-Network \$10 copay for Medicare-covered individual or group visits.</p>	<p>In-Network \$0 copay for Medicare-covered visits.</p>	<p>In-Network \$0 copay for Medicare-covered visits.</p>
<p>Out-of-Network \$15 copay for outpatient substance abuse benefits.</p>	<p>Out-of-Network \$15 copay for outpatient substance abuse benefits.</p>	<p>Out-of-Network \$10 copay for outpatient substance abuse benefits.</p>	<p>Out-of-Network \$10 copay for outpatient substance abuse benefits.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
13 - Outpatient Services/Surgery	20% coinsurance for the doctor 20% of outpatient facility charges	<p>General Authorization rules may apply.</p> <p>In-Network \$100 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$100 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network \$200 copay for ambulatory surgical center benefits.</p> <p>\$200 copay for outpatient hospital facility benefits.</p>
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	<p>In-Network \$75 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$75 copay for ambulance benefits.</p>
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	<p>20% coinsurance for the doctor</p> <p>20% of facility charge, or a set copay per emergency room visit.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$50 copay for Medicare-covered emergency room visits.</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network \$75 copay for ambulatory surgical center benefits.</p> <p>\$75 copay for outpatient hospital facility benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network \$75 copay for ambulatory surgical center benefits.</p> <p>\$75 copay for outpatient hospital facility benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network \$75 copay for ambulatory surgical center benefits.</p> <p>\$75 copay for outpatient hospital facility benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network \$75 copay for ambulatory surgical center benefits.</p> <p>\$75 copay for outpatient hospital facility benefits.</p>
<p>In-Network \$25 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$25 copay for ambulance benefits.</p>	<p>In-Network \$25 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$25 copay for ambulance benefits.</p>	<p>In-Network \$0 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$0 copay for ambulance benefits.</p>	<p>In-Network \$0 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network \$0 copay for ambulance benefits.</p>
<p>General \$50 copay for Medicare-covered emergency room visits.</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p>	<p>General \$50 copay for Medicare-covered emergency room visits.</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p>	<p>General 0% of the cost (up to \$50) for Medicare-covered emergency room visits</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p>	<p>General 0% of the cost (up to \$50) for Medicare-covered emergency room visits</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
Emergency Care <i>continued</i>		<p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General \$35 copay for Medicare-covered urgently needed care visits.</p>
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$30 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network \$40 copay for Occupational Therapy benefits.</p> <p>\$40 copay for Physical and/or Speech/Language Therapy visits.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit.</p>	<p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p>	<p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p>
<p>General \$15 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p>	<p>General \$15 copay for Medicare-covered urgently needed care visits.</p>
<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>
<p>In-Network \$15 copay for Medicare-covered Occupational Therapy visits.</p>	<p>In-Network \$15 copay for Medicare-covered Occupational Therapy visits.</p>	<p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits.</p>	<p>In-Network \$0 copay for Medicare-covered Occupational Therapy visits.</p>
<p>\$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>\$15 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>\$0 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>
<p>Out-of-Network \$20 copay for Occupational Therapy benefits.</p>	<p>Out-of-Network \$20 copay for Occupational Therapy benefits.</p>	<p>Out-of-Network \$10 copay for Occupational Therapy benefits.</p>	<p>Out-of-Network \$10 copay for Occupational Therapy benefits.</p>
<p>\$20 copay for Physical and/or Speech/Language Therapy visits.</p>	<p>\$20 copay for Physical and/or Speech/Language Therapy visits.</p>	<p>\$10 copay for Physical and/or Speech/Language Therapy visits.</p>	<p>\$10 copay for Physical and/or Speech/Language Therapy visits.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 30% of the cost for durable medical equipment.</p>
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 30% of the cost for prosthetic devices.</p>
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	<p>20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$15 copay for Diabetes supplies.</p> <p>Out-of-Network \$0 copay for Diabetes</p>

Summary of Benefits Report

Network Platinum <i>Plus</i> (PPO)	Network Platinum <i>Plus</i> Pharmacy (PPO)	Network Platinum <i>Premier</i> (PPO)	Network Platinum <i>Premier</i> Pharmacy (PPO)
General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.
In-Network 10% of the cost for Medicare-covered items.	In-Network 10% of the cost for Medicare-covered items.	In-Network \$0 copay for Medicare-covered items.	In-Network \$0 copay for Medicare-covered items.
Out-of-Network 20% of the cost for durable medical equipment.	Out-of-Network 20% of the cost for durable medical equipment.	Out-of-Network 10% of the cost for durable medical equipment.	Out-of-Network 10% of the cost for durable medical equipment.
General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.
In-Network 10% of the cost for Medicare-covered items.	In-Network 10% of the cost for Medicare-covered items.	In-Network \$0 copay for Medicare-covered items.	In-Network \$0 copay for Medicare-covered items.
Out-of-Network 20% of the cost for prosthetic devices.	Out-of-Network 20% of the cost for prosthetic devices.	Out-of-Network 10% of the cost for prosthetic devices.	Out-of-Network 10% of the cost for prosthetic devices.
General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.
In-Network \$0 copay for Diabetes self-monitoring training.	In-Network \$0 copay for Diabetes self-monitoring training.	In-Network \$0 copay for Diabetes self-monitoring training.	In-Network \$0 copay for Diabetes self-monitoring training.
\$0 copay for Nutrition Therapy for Diabetes.	\$0 copay for Nutrition Therapy for Diabetes.	\$0 copay for Nutrition Therapy for Diabetes.	\$0 copay for Nutrition Therapy for Diabetes.
\$10 copay for Diabetes supplies.	\$10 copay for Diabetes supplies.	\$0 copay for Diabetes supplies.	\$0 copay for Diabetes supplies.
Out-of-Network 20% of the cost for	Out-of-Network 20% of the cost for	Out-of-Network \$10 copay for Diabetes	Out-of-Network \$10 copay for Diabetes

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
<p>Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies <i>continued</i></p>		<p>self-monitoring training.</p> <p>\$35 copay for Diabetes supplies.</p> <p>\$5 copay for Nutrition Therapy for Diabetes.</p>
<p>21 - Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>In-Network</p> <p>\$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests <p>5% of the cost for Medicare-covered X-rays.</p> <p>\$60 copay (or 5% of the cost) for Medicare-covered diagnostic radiology services.</p> <p>5% of the cost for Medicare-covered therapeutic radiology services.</p> <p>Out-of-Network</p> <p>\$10 copay for diagnostic procedures, tests, and lab services.</p> <p>\$110 copay for diagnostic radiology services.</p> <p>10% of the cost for therapeutic radiology services.</p> <p>10% of the cost for outpatient x-rays.</p> <p>10% of the cost for diagnostic radiology services.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
Diabetes supplies.	Diabetes supplies.	self-monitoring training.	self-monitoring training.
\$0 copay for Diabetes self-monitoring training.	\$0 copay for Diabetes self-monitoring training.	\$10 copay for Nutrition Therapy for Diabetes.	\$10 copay for Nutrition Therapy for Diabetes.
\$15 copay for Nutrition Therapy for Diabetes.	\$15 copay for Nutrition Therapy for Diabetes	10% of the cost for Diabetes supplies.	10% of the cost for Diabetes supplies.
General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.	General Authorization rules may apply.
In-Network \$5 copay for Medicare-covered lab services. \$5 copay for Medicare-covered diagnostic procedures and tests. \$5 copay for Medicare-covered X-rays. \$5 to \$50 copay for Medicare-covered diagnostic radiology services. \$5 copay for Medicare-covered therapeutic radiology services.	In-Network \$5 copay for Medicare-covered lab services. \$5 copay for Medicare-covered diagnostic procedures and tests. \$5 copay for Medicare-covered X-rays. \$5 to \$50 copay for Medicare-covered diagnostic radiology services. \$5 copay for Medicare-covered therapeutic radiology services.	In-Network \$0 copay for Medicare-covered: - lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays). - therapeutic radiology services.	In-Network \$0 copay for Medicare-covered: - lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays). - therapeutic radiology services.
Out-of-Network \$10 copay for diagnostic procedures, tests, and lab services. \$10 copay for outpatient x-rays. \$100 copays for diagnostic radiology services. 10% of the cost for therapeutic radiology services.	Out-of-Network \$10 copay for diagnostic procedures, tests, and lab services. \$10 copay for outpatient x-rays. \$100 copays for diagnostic radiology services. 10% of the cost for therapeutic radiology services	Out-of-Network \$5 copay for diagnostic procedures, tests, and lab services. \$5 copay for outpatient x-rays. \$5 copays for diagnostic radiology services. \$10 copay for therapeutic radiology services. \$25 copays for diagnostic radiology services.	Out-of-Network \$5 copay for diagnostic procedures, tests, and lab services. \$5 copay for outpatient x-rays. \$5 copays for diagnostic radiology services. \$10 copay for therapeutic radiology services. \$25 copays for diagnostic radiology services.

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
PREVENTIVE SERVICES		
22 - Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network \$0 copay for Medicare-covered bone mass measurement. Out-of-Network \$5 copay for Medicare-covered bone mass measurement.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	In-Network \$0 copay for Medicare-covered colorectal screenings. Out-of-Network \$5 copay for colorectal screenings.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. Out-of-Network \$5 copay for immunizations.
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	In-Network \$0 copay for Medicare-covered screening mammograms. Out-of-Network \$5 copay for screening mammograms.

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
In-Network \$0 copay for Medicare-covered bone mass measurement.	In-Network \$0 copay for Medicare-covered bone mass measurement.	In-Network \$0 copay for Medicare-covered bone mass measurement.	In-Network \$0 copay for Medicare-covered bone mass measurement.
Out-of-Network \$10 copay for Medicare-covered bone mass measurement.	Out-of-Network \$10 copay for Medicare-covered bone mass measurement.	Out-of-Network \$10 copay for Medicare-covered bone mass measurement.	Out-of-Network \$10 copay for Medicare-covered bone mass measurement.
In-Network \$0 copay for Medicare-covered colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings.	In-Network \$0 copay for Medicare-covered colorectal screenings.
Out-of-Network \$10 copay for colorectal screenings.	Out-of-Network \$10 copay for colorectal screenings.	Out-of-Network \$10 copay for colorectal screenings.	Out-of-Network \$10 copay for colorectal screenings.
In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines.
Out-of-Network \$0 copay for immunizations.	Out-of-Network \$0 copay for immunizations.	Out-of-Network \$0 copay for immunizations.	Out-of-Network \$0 copay for immunizations.
In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.	In-Network \$0 copay for Medicare-covered screening mammograms.
Out-of-Network \$10 copay for screening mammograms.	Out-of-Network \$10 copay for screening mammograms.	Out-of-Network \$10 copay for screening mammograms.	Out-of-Network \$10 copay for screening mammograms.

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
26 - Pap Smears and Pelvic Exams (for women with Medicare)	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p> <p>Out-of-Network \$5 copay for pap smears and pelvic exams.</p>
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	<p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Out-of-Network \$5 copay for prostate cancer screening.</p>
28 - End-Stage Renal Disease	<p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$20 copay for renal dialysis.</p> <p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p> <p>Out-of-Network \$35 copay for renal dialysis.</p> <p>\$5 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams - up to 1 additional pap smear(s) and pelvic exam(s) every year.</p>	<p>In-Network \$0 copay for Medicare-covered pap smears and pelvic exams -up to 1 additional pap smear(s) and pelvic exam(s) every year.</p>
<p>Out-of-Network \$10 copay for pap smears and pelvic exams.</p>	<p>Out-of-Network \$10 copay for pap smears and pelvic exams.</p>	<p>Out-of-Network \$10 copay for pap smears and pelvic exams.</p>	<p>Out-of-Network \$10 copay for pap smears and pelvic exams.</p>
<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p>
<p>Out-of-Network \$10 copay for prostate cancer screening.</p>	<p>Out-of-Network \$10 copay for prostate cancer screening.</p>	<p>Out-of-Network \$10 copay for prostate cancer screening.</p>	<p>Out-of-Network \$10 copay for prostate cancer screening.</p>
<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>	<p>General Authorization rules may apply.</p>
<p>In-Network \$10 copay for renal dialysis.</p>	<p>In-Network \$10 copay for renal dialysis.</p>	<p>In-Network \$0 copay for renal dialysis.</p>	<p>In-Network \$0 copay for renal dialysis.</p>
<p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>\$0 copay for Nutrition Therapy for End-Stage Renal Disease.</p>
<p>Out-of-Network \$15 copay for renal dialysis.</p>	<p>Out-of-Network \$15 copay for renal dialysis.</p>	<p>Out-of-Network \$10 copay for renal dialysis.</p>	<p>Out-of-Network \$10 copay for renal dialysis.</p>
<p>\$15 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>\$15 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>\$10 copay for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>\$10 copay for Nutrition Therapy for End-Stage Renal Disease.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
29 - Prescription Drugs	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>30% of the cost for Part B drugs out-of-network.</p> <p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.nppdrugplans.com/cgi-bin/formulary-2009/index.pl on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none">-have limited incomes,-live in long term care facilities, <p>or</p> <ul style="list-style-type: none">-have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>Drugs covered under Medicare Part B</p> <p>General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>20% of the cost for Part B drugs out-of-network</p>	<p>Drugs covered under Medicare Part B</p> <p>General 10% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p> <p>20% of the cost for Part B drugs out-of-network</p>	<p>Drugs covered under Medicare Part B</p> <p>General \$0 copay for Part B-covered drugs.</p> <p>10% of the cost for Part B drugs out-of-network.</p>	<p>Drugs covered under Medicare Part B</p> <p>General \$0 copay for Part B-covered drugs.</p> <p>10% of the cost for Part B drugs out-of-network.</p>
<p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p> <p>Most drugs not covered.</p>	<p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.nppdrugplans.com/cgi-bin/formulary-2009/index.pl on the web.</p> <p>Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if</p>	<p>Drugs Covered under Medicare Part D</p> <p>General This plan does not offer prescription drug coverage.</p> <p>Most drugs not covered.</p>	<p>Drugs Covered under Medicare Part D</p> <p>General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at http://www.nppdrugplans.com/cgi-bin/formulary-2009/index.pl on the web.</p> <p>Different out-of-pocket costs may apply for people who -have limited incomes, -live in long term care facilities, or -have access to Indian/Tribal/Urban (Indian Health Service).</p> <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
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Prescription Drugs *continued*

you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Network PlatinumSelect (PPO) for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education

Summary of Benefits Report

Network PlatinumPlus (PPO)

Network PlatinumPlus Pharmacy (PPO)

Network PlatinumPremier (PPO)

Network PlatinumPremier Pharmacy (PPO)

you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Network PlatinumPlus Pharmacy (PPO) for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or

you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).

Total yearly drug costs are the total drug costs paid by both you and the plan.

The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

Some drugs have quantity limits.

Your provider must get prior authorization from Network Platinum Premier Pharmacy (PPO) for certain drugs.

The plan will pay for certain over-the-counter drugs as part of its utilization management program. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. Contact the plan for details.

You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or

Summary of Benefits Report

Benefit Category

Original Medicare

Network PlatinumSelect (PPO)

Prescription Drugs *continued*

requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

If you request a formulary exception for a drug and Network PlatinumSelect (PPO) approves the exception, you will pay Non-Preferred Brand cost sharing for that drug.

In-Network
\$0 deductible.

Initial Coverage
You pay the following until total yearly drug costs reach \$2,500:

Retail Pharmacy
Preferred Generic
- \$7 copay for a one-month (31-day) supply of drugs in this tier.

- \$19 copay for a three-month (90-day) supply of drugs in this tier.

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Network PlatinumPlus Pharmacy (PPO) approves the exception, you will pay Non-Preferred Brand cost sharing for that drug.</p> <p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,500:</p> <p>Retail Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p>		<p>patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.</p> <p>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>If you request a formulary exception for a drug and Network PlatinumPremier Pharmacy (PPO) approves the exception, you will pay Non-Preferred Brand costsharing for that drug.</p> <p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,500:</p> <p>Retail Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
Prescription Drugs <i>continued</i>		<p data-bbox="1175 296 1515 443">Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 485 1515 594">- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p data-bbox="1175 636 1515 783">Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 825 1515 934">- \$68 copay for a three-month (90-day) supply of drugs in this tier.</p> <p data-bbox="1175 976 1515 1123">Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 1165 1515 1274">- \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p data-bbox="1175 1316 1515 1505">Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 1547 1515 1778">Long Term Care Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 1820 1515 1967">Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$68 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Long Term Care Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p>		<p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$68 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Long Term Care Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
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Prescription Drugs *continued*

Preferred Brand
- \$26 copay for a one-month (31-day) supply of drugs in this tier.

Non-Preferred Brand
- \$53 copay for a one-month (31-day) supply of drugs in this tier.

Specialty
- 25% coinsurance for a one-month (31-day) supply of drugs in this tier.

Mail Order Pharmacy

Preferred Generic
- \$7 copay for a one-month (31-day) supply of drugs in this tier.

- \$19 copay for a three-month (90-day) supply of drugs in this tier.

Non-Preferred Generic
- \$7 copay for a one-month (31-day) supply of drugs in this tier.

- \$19 copay for a three-month (90-day) supply of drugs in this tier.

Preferred Brand
- \$26 copay for a one-month (31-day) supply of drugs in this tier.

- \$68 copay for a three-month (90-day) supply of drugs in this tier.

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Mail Order Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$68 copay for a three-month (90-day) supply of drugs in this tier.</p>		<p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Mail Order Pharmacy Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$19 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$68 copay for a three-month (90-day) supply of drugs in this tier.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
Prescription Drugs <i>continued</i>		<p data-bbox="1175 300 1515 443">Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 489 1515 594">- \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p data-bbox="1175 640 1515 825">Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p data-bbox="1175 871 1515 1087">Coverage Gap After your total yearly drug costs reach \$2,500, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p data-bbox="1175 1134 1515 1585">Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of: A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$ 6.30 copay for all other drugs, or - 5% coinsurance.</p> <p data-bbox="1175 1631 1515 1925">Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Coverage Gap The plan covers many generics (65%–99% of formulary generic drugs) through the coverage gap.</p> <p>You pay the following:</p> <p>Retail Pharmacy Preferred Generic - \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.</p> <p>- \$24 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>Non-Preferred Generic - \$9 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$24 copay for a three-month (90-day) supply of drugs in this tier.</p>		<p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$150 copay for a three-month (90-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Coverage Gap The plan covers many generics (65%–99% of formulary generic drugs) through the coverage gap.</p> <p>You pay the following:</p> <p>Retail Pharmacy Preferred Generic - \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.</p> <p>- \$24 copay for a three-month (90-day) supply of all drugs covered in this tier.</p> <p>Non-Preferred Generic - \$9 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>- \$24 copay for a three-month (90-day) supply of drugs in this tier.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
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Prescription Drugs *continued*

pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Network PlatinumSelect (PPO).

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,500:

Out-of-Network Pharmacy

Preferred Generic
- \$7 copay for a one-month (31-day) supply of drugs in this tier.

Non-Preferred Generic
- \$7 copay for a one-month (31-day) supply of drugs in this tier.

Preferred Brand
- \$26 copay for a one-month (31-day) supply of drugs in this tier.

Non-Preferred Brand
- \$53 copay for a one-

Summary of Benefits Report

Network PlatinumPlus (PPO)

Network PlatinumPlus Pharmacy (PPO)

Network PlatinumPremier (PPO)

Network PlatinumPremier Pharmacy (PPO)

Long Term Care Pharmacy

Preferred Generic
- \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.

Non-Preferred Generic
- \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.

Mail Order

Preferred Generic
- \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.

- \$24 copay for a three-month (90-day) supply of all drugs covered in this tier.

Non-Preferred Generic
- \$9 copay for a one-month (31-day) supply of drugs in this tier.

- \$24 copay for a three-month (90-day) supply of drugs in this tier.

For all other covered drugs, after your total yearly drug costs reach \$2,500, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.

Long Term Care Pharmacy

Preferred Generic
- \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.

Non-Preferred Generic
- \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.

Mail Order

Preferred Generic
- \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.

- \$24 copay for a three-month (90-day) supply of all drugs covered in this tier.

Non-Preferred Generic
- \$9 copay for a one-month (31-day) supply of drugs in this tier.

- \$24 copay for a three-month (90-day) supply of drugs in this tier.

For all other covered drugs, after your total yearly drug costs reach \$2,500, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
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Prescription Drugs *continued*

month (31-day) supply of drugs in this tier.

Specialty
- 25% coinsurance for a one-month (31-day) supply of drugs in this tier.

Out-of-Network Coverage Gap

After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550.

You will not be reimbursed by Network PlatinumSelect (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumSelect (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Out-of-Network Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following:

Summary of Benefits Report

Network PlatinumPlus (PPO)

Network PlatinumPlus Pharmacy (PPO)

Network PlatinumPremier (PPO)

Network PlatinumPremier Pharmacy (PPO)

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Network PlatinumPlus Pharmacy (PPO).

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,500:

Catastrophic Coverage

After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.

Out-of-Network

Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from Network PlatinumPremier Pharmacy (PPO).

Out-of-Network Initial Coverage

You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach \$2,500:

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
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Prescription Drugs *continued*

A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p>Preferred Generic - \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.</p> <p>Non-Preferred Generic - \$9 copay for a one-month (31-day) supply of drugs in this tier.</p>		<p>Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Generic - \$7 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Preferred Brand - \$26 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Non-Preferred Brand - \$53 copay for a one-month (31-day) supply of drugs in this tier.</p> <p>Specialty - 25% coinsurance for a one-month (31-day) supply of drugs in this tier.</p> <p>Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the full cost of the drug minus the following:</p> <p>Preferred Generic - \$9 copay for a one-month (31-day) supply of all drugs covered in this tier.</p> <p>Non-Preferred Generic - \$9 copay for a one-month (31-day) supply of drugs in this tier.</p>

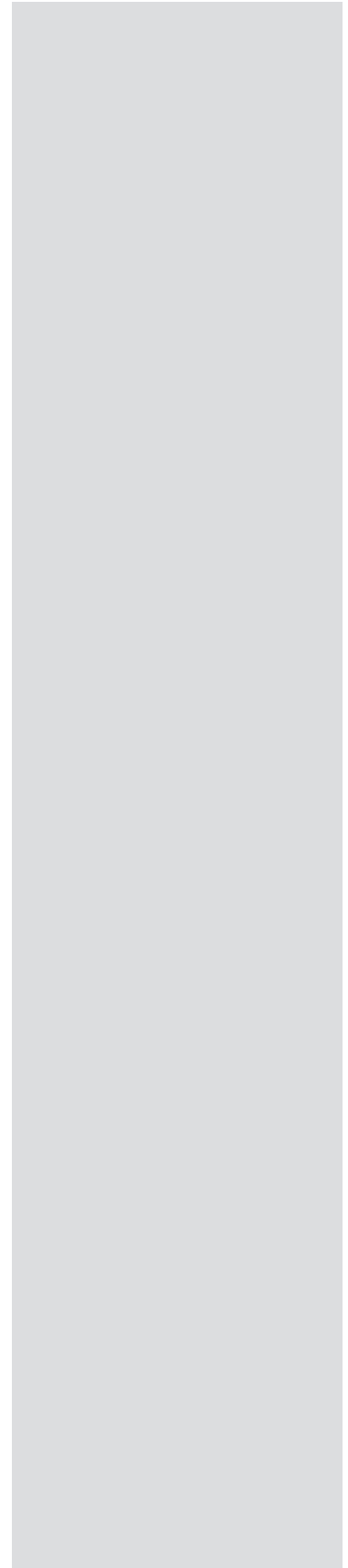
Summary of Benefits Report

Benefit Category

Original Medicare

**Network
PlatinumSelect (PPO)**

Prescription Drugs *continued*



Summary of Benefits Report

Network PlatinumPlus (PPO)

Network PlatinumPlus Pharmacy (PPO)

Network PlatinumPremier (PPO)

Network PlatinumPremier Pharmacy (PPO)

Preferred Brand
-After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Network PlatinumPlus Pharmacy (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumPlus Pharmacy (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Non-Preferred Brand
-After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Network PlatinumPlus Pharmacy (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumPlus Pharmacy (PPO) so we can add the amounts you spent out-of-network to

Preferred Brand
-After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Network PlatinumPremier Pharmacy (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumPremier Pharmacy (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.

Non-Preferred Brand
-After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Network PlatinumPremier Pharmacy (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumPremier Pharmacy (PPO) so we can add the amounts you

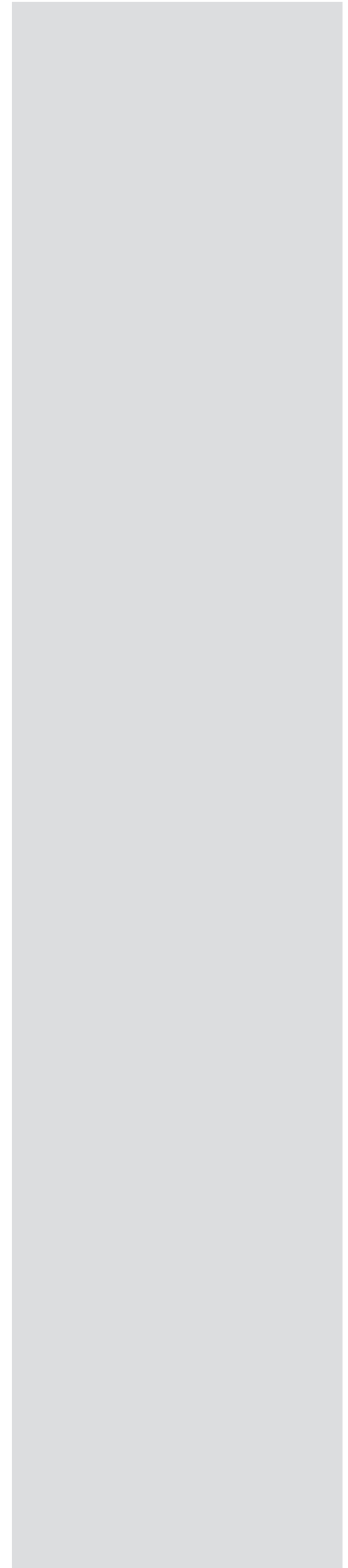
Summary of Benefits Report

Benefit Category

Original Medicare

**Network
PlatinumSelect (PPO)**

Prescription Drugs *continued*



Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
	<p>your total out-of-pocket costs for the year.</p> <p>Specialty -After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Network PlatinumPlus Pharmacy (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumPlus Pharmacy (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: -A \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.</p>		<p>spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Specialty -After your total yearly drug costs reach \$2,500, you pay 100% of the pharmacy's full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by Network PlatinumPremier Pharmacy (PPO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to Network PlatinumPremier Pharmacy (PPO) so we can add the amounts you spent out-of-network to your total out-of-pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: - A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs, or 5% coinsurance.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>General Authorization rules may apply.</p> <p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$30 copay for Medicare-covered dental benefits.</p> <p>Out-of-Network \$40 copay for comprehensive dental benefits.</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network In general, routine hearing exams and hearing aids not covered.</p> <p>\$30 copay for Medicare-covered diagnostic hearing exams.</p> <p>Out-of-Network \$40 copay for hearing exams.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$15 copay for Medicare-covered dental benefits.</p> <p>Out-of-Network \$20 copay for comprehensive dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$15 copay for Medicare-covered dental benefits.</p> <p>Out-of-Network \$20 copay for comprehensive dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$0 copay for Medicare-covered dental benefits.</p> <p>Out-of-Network \$5 copay for comprehensive dental benefits.</p>	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>\$0 copay for Medicare-covered dental benefits.</p> <p>Out-of-Network \$5 copay for comprehensive dental benefits.</p>
<p>In-Network In general, routine hearing exams and hearing aids not covered</p> <p>\$15 copay for Medicare-covered diagnostic hearing exams.</p> <p>Out-of-Network \$20 copay for hearing exams.</p>	<p>In-Network In general, routine hearing exams and hearing aids not covered.</p> <p>\$15 copay for Medicare-covered diagnostic hearing exams.</p> <p>Out-of-Network \$20 copay for hearing exams.</p>	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams</p> <p>Up to 1 routine hearing test(s) every year.</p> <p>\$0 copay for up to 1 hearing aid(s) every year.</p> <p>\$100 limit for hearing aids every year.</p> <p>Out-of-Network \$10 copay for hearing exams.</p> <p>\$0 copay for hearing aids.</p>	<p>In-Network \$0 copay for Medicare-covered diagnostic hearing exams</p> <p>Up to 1 routine hearing test(s) every year.</p> <p>\$0 copay for up to 1 hearing aid(s) every year.</p> <p>\$100 limit for hearing aids every year.</p> <p>Out-of-Network \$10 copay for hearing exams.</p> <p>\$0 copay for hearing aids.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
32 - Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <p>\$30 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$30 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for up to 1 pair(s) of glasses every year</p> <p>\$0 copay for up to 1 pair(s) of contacts every year</p> <p>\$100 limit for eye wear every year.</p> <p>Out-of-Network</p> <p>\$40 copay for eye exams.</p> <p>\$40 copay for eye wear.</p>
33 - Physical Exams	<p>20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network</p> <p>\$10 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>\$10 copay for Medicare-covered benefits.</p> <p>Out-of-Network</p> <p>\$20 copay for routine exams.</p>

Summary of Benefits Report

Network <i>PlatinumPlus</i> (PPO)	Network <i>PlatinumPlus</i> Pharmacy (PPO)	Network <i>PlatinumPremier</i> (PPO)	Network <i>PlatinumPremier</i> Pharmacy (PPO)
<p>In-Network \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$15 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for up to 1 pair(s) of glasses every year</p> <p>\$0 copay for up to 1 pair(s) of contacts every year</p> <p>\$100 limit for eye wear every year.</p> <p>Out-of-Network \$20 copay for eye wear. \$20 copay for eye exams.</p>	<p>In-Network \$15 copay for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>\$15 copay for exams to diagnose and treat diseases and conditions of the eye.</p> <p>\$0 copay for up to 1 pair(s) of glasses every year</p> <p>\$0 copay for up to 1 pair(s) of contacts every year</p> <p>\$100 limit for eye wear every year.</p> <p>Out-of-Network \$20 copay for eye wear. \$20 copay for eye exams.</p>	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye – and up to 1 routine eye exam every year.</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</p> <p>\$0 copay for up to 1 pair(s) of contacts every year</p> <p>Up to 1 pair(s) of glasses every year</p> <p>\$100 limit for eye wear every year.</p> <p>Out-of-Network \$10 copay for eye exams. \$10 copay for eye wear.</p>	<p>In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after cataract surgery</p> <p>\$0 copay for up to 1 pair(s) of contacts every year</p> <p>Up to 1 pair(s) of glasses every year</p> <p>\$100 limit for eye wear every year.</p> <p>Out-of-Network \$10 copay for eye exams. \$10 copay for eye wear.</p>
<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network \$10 copay for routine exams.</p>	<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network \$10 copay for routine exams.</p>	<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network \$10 copay for routine exams.</p>	<p>In-Network \$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p> <p>Out-of-Network \$10 copay for routine exams.</p>

Summary of Benefits Report

Benefit Category	Original Medicare	Network PlatinumSelect (PPO)
Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Nutritional Benefit - Additional Smoking Cessation - Nursing Hotline - Other Wellness Benefits - \$0 copay for each Medicare-covered smoking cessation counseling session. <p>Out-of-Network 50% of the cost for Health and Wellness services.</p>
Transportation (Routine)	Not covered.	<p>In-Network This plan does not cover routine transportation.</p>
Acupuncture	Not covered.	<p>In-Network This plan does not cover Acupuncture.</p>

Summary of Benefits Report

Network PlatinumPlus (PPO)	Network PlatinumPlus Pharmacy (PPO)	Network PlatinumPremier (PPO)	Network PlatinumPremier Pharmacy (PPO)
<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Nutritional Benefit - Additional Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline - Other Wellness Benefits - \$0 copay for each Medicare-covered smoking cessation counseling session. <p>Out-of-Network 50% of the cost for Health and Wellness services.</p>	<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Nutritional Benefit - Additional Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline - Other Wellness Benefits - \$0 copay for each Medicare-covered smoking cessation counseling session. <p>Out-of-Network 50% of the cost for Health and Wellness services.</p>	<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Additional Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline - Other Wellness Benefits - \$0 copay for each Medicare-covered smoking cessation counseling session. <p>Out-of-Network 50% of the cost for Health and Wellness services.</p>	<p>In-Network This plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training - Additional Smoking Cessation - Health Club Membership/Fitness Classes - Nursing Hotline - Other Wellness Benefits - \$0 copay for each Medicare-covered smoking cessation counseling session. <p>Out-of-Network 50% of the cost for Health and Wellness services.</p>
<p>In-Network This plan does not cover routine transportation.</p>	<p>In-Network This plan does not cover routine transportation.</p>	<p>In-Network This plan does not cover routine transportation.</p>	<p>In-Network This plan does not cover routine transportation.</p>
<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>	<p>In-Network This plan does not cover Acupuncture.</p>

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

Network Health Insurance Corporation – The Company You Can Trust

Network Health Insurance Corporation is a Medicare Advantage Preferred Provider Organization (PPO) that includes the same providers as Network Health Plan. Network Health Plan has been meeting the needs of people in the Fox Valley since 1982. From the beginning, we've built a reputation for providing quality care to individuals and employees of companies all over the area. Now we offer that same quality of care in our Network Platinum Medicare Advantage PPO plans.

Caring, Personalized Customer Service – Delivered Locally

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

Access to Providers

Network Health Insurance Corporation allows you the opportunity to choose services from any Medicare eligible provider who accepts our terms and conditions. It is important to inform your provider what plan you are currently in prior to receiving services from that provider. If your provider accepts the terms and conditions of Medicare, they will accept the terms and conditions of our Medicare Advantage Plans. If they do not accept the terms and conditions of Medicare, their costs are often higher, which means you will pay more.

Travel Benefit

Within the United States

When you are traveling outside the state of Wisconsin and need medical care in the remaining 49 states, please show your Network Platinum Medicare Advantage plan Member ID card, and you will receive Medicare covered services at the in-network level of copayments or coinsurance. This applies to all Medicare covered services including non-emergent care from providers who accept Medicare assignment.

Outside the United States

Emergency and urgent care services are covered outside of the United States. Your cost share will be 25% up to an annual maximum of \$100,000.

Pre-authorization

Some of the covered services listed in the Benefits Chart in this summary require "prior authorization," which means approval in advance. These specific services are covered only if your Network Health Insurance Corporation's plan doctor or provider requests and receives prior authorization from Network Health Insurance Corporation. If you need to access these services, you need to make sure that your prior authorization has been received before you

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

receive the services. Covered services that require prior authorization are listed in the Benefits Chart. You will pay more if you receive covered services from a non-plan physician or provider.

Preventive Services

A lab screening is included with your routine annual physical. It includes a lipid profile, glucose monitoring, and complete blood count analysis (CBC).

Health and Wellness Benefits

Network Health Insurance Corporation offers a variety of Health and Wellness Education services.

They include:

- Written health education materials, including newsletters
- Smoking cessation
- Nutritional training and benefits
- Nurse*Direct* Nurse hotline
- Courage Program (NEW for 2010)*

*The Courage Program is designed to prevent heart attacks and control symptoms without need for further revascularization; improve exercise tolerance and quality of life. Patients will be working with a dietician, a cardiologist, and an exercise physiologist throughout the program.

For additional information on the services and benefits available to you, contact Network Health Insurance Corporation Customer Service Department at 1-800-378-5234, 8:00 a.m. to 5:00 p.m. Monday through Friday. TTY/TDD users call 1-800-947-3529.

Health Club Membership

Network Platinum*Plus* (PPO), Network Platinum*Plus* Pharmacy (PPO), Network Platinum*Premier* (PPO), and Network Platinum*Premier* Pharmacy (PPO) will include a Health Club benefit for our members.

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

Disease Management

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

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

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

Case Management Services

Care Management Coordinators work with you to manage your health conditions. They include you in your health care decision making, support you in managing your health conditions to help put you in control of your health, and increase your sense of well-being. They also:

- Provide education on the signs that a health condition is worsening
- Educate you on when you should contact your health care provider
- Review your medications and treatments with you
- Coordinate your care with your health care provider(s)

Additional Benefits Not Covered by Medicare

Eye glasses or contact lenses:

All Network Medicare Advantage plans (PPO) cover up to \$100 maximum toward the purchase of new eye glasses or contact lenses with any new eyeglass prescription (does not have to be following cataract surgery). You are entitled to one pair of glasses per calendar year.

Hearing aides:

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

Maximum Out-of-Pocket Expenses

Network Platinum *Select*(PPO)

The maximum you will pay out-of-pocket for Medicare-covered services both in and out-of-network will be \$2,900 annually, excluding Part D prescription drug costs.

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

The maximum that you will pay out-of-pocket for Medicare-covered services both in and out-of-network will be \$2,000 annually, excluding Part D prescription drug costs. The maximum you will pay out-of-pocket for Medicare Part B drugs when received in network, including chemotherapy, is \$1000 annually. The maximum you will pay out-of-pocket for inpatient hospitalization for out-of-network hospital services is \$1000 annually. These amounts are included in the \$2000 total out-of-pocket maximum.

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

There are No out-of pocket expenses for Medicare covered services when receiving care from in-network providers, with the exception of Medicare Part D drugs. If you choose to see out-of-network providers for Medicare covered services, the maximum you will pay out-of-pocket will be \$1000 annually, with the exception of Medicare Part D drugs.

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

Cost Share Reduction

If you call Network Health Insurance Corporation in advance (pre-notify), your copayments for the following benefits will be reduced when received out-of-network:

Network Platinum *Select* (PPO)

- Skilled nursing facility (out-of-network)-from \$70 per day for days 1-100 to \$50 per day for days 1-100.

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

- Inpatient psychiatric hospitalization ~ from \$125 per day to \$75 per day for days 1- 7.
- Skilled nursing facility ~ from \$50 per day for days 1-100 to \$0 per day for days 1-20 and \$50 per day for days 21-100.

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

- Durable medical equipment, prosthetic devices, diabetic monitoring supplies, or Medicare Part B drugs; from 10% to 5% coinsurance cost share amount.
- Inpatient hospitalization; from \$75 per day to \$35 per day for days 1- 7.
- Inpatient psychiatric hospitalization; from \$125 per day to \$75 per day for 7 days.
- Skilled nursing facility; from \$25 per day for days 1-100 to \$0 per day for days 1-20 and \$25 per day for days 21-100.

Prescription Drug Coverage

During the Coverage Gap

Network Platinum*Plus* Pharmacy (PPO) and Network Platinum*Premier* Pharmacy (PPO) will cover generic drugs once you reach \$2,500 (coverage gap) in total drug costs per year.

Network Platinum*Select* does not cover generic or brand name drugs once you reach \$2,500 (coverage gap) in total drug costs per year but will resume covering generic and brand drugs after your total out-of-pocket of \$4,550 has been reached.

See Page 41 in Section 2 of this summary for details.

Additional Information

- **Prior Authorization**-You may be required to get prior approval from Network Health Insurance Corporation before you can fill your prescription.
- **Quantity Limits**-For certain drugs, the amount of the medication covered may be limited during any single prescription fill.
- **Step Therapy**-You may be required to first try a certain drug for your condition before another drug is covered.

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

Frequently asked questions~

Who can enroll?

To be eligible to enroll in a Network Health Insurance Corporation (NHIC) Medicare Advantage plan (PPO) you must:

- Have both Medicare Part A and Part B (if you have questions about your eligibility, contact Medicare at 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048, 24 hours a day, 7 days a week)
- Continue to pay your Medicare Part B premium, unless it is otherwise paid for under Medicaid or by another third party.
- Reside in the NHIC service area (Brown, Calumet, Dodge, Fond du Lac, Green Lake, Manitowoc, Marquette, Outagamie, Portage, Sheboygan, Waupaca, Waushara, or Winnebago counties, WI).
- Not have End Stage Renal Disease (ESRD).

When can I enroll?

You can enroll in a Medicare Advantage plan for the first time or change from one plan to another during the *Annual Coordinated Election Period (ACEP)*, which is from November 15 to December 31 of each year.

Additionally, you may enroll during the Initial Election Period (IEP)-When you are first eligible for Medicare, you can enroll up to 3 months before your birthday, the month of your 65th birthday, and 3 months after your birthday.

If any of the following situations apply, you can enroll during a *Special Election Period (SEP)*:

- you recently moved into or out of the service area
- you are eligible for Medicaid
- you reside in a Skilled Nursing Facility
- your employer group health insurance plan or current Medicare Advantage plan is no longer offered

There is an *Open Enrollment Period (OEP)* each year from January 1 through March 31; you can enroll in a Medicare Advantage plan during this time, however you can't add or drop Medicare Part D prescription drug coverage during this time.

How do I enroll?

- In person—attend a local seminar or schedule an in-home appointment with one of our certified representatives. Just call 1-800-983-7587 to get a list of seminars in your area or ask to schedule a visit with a representative in your home.
- Online—Visit www.nppdrugplans.com and follow the simple instructions.
- By Mail—Call 1-800-983-7587 and we will mail you an application.
- By Phone—Call 1-800-983-7587 for instructions.

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

How do I pay my premium?

You can choose a convenient payment option directly on your enrollment application. The options include:

Coupon Book: Coupon books are mailed monthly. You may not receive a coupon book until the month following your effective date. You do not need to make your premium payment until you receive your coupon book. If you prefer to make a premium payment before you receive your monthly coupon book, please call Customer Service at 1-800-378-5234 for more information.

EFT (automatic bank withdrawal): With this option, your monthly premium will be deducted from your checking or savings account on the 7th of the month. This option will begin 2 months after your effective date of confirmed enrollment. If you prefer to pay the first month premium by check, or give Network Health Insurance Corporation permission to withdraw the first and second months' premium together, please call Customer Service at 1-800-378-5234 for more information.

SSA Withdrawal: If you choose your premium to be drafted from your Social Security check, this process can take up to 90 days to set up. Once this payment option has been confirmed by CMS, they may take up to three premium payments, if owed, on the first withdrawal month. If the amount you owe exceeds \$200, CMS will not draft more than that amount from one month's Social Security check. If this occurs, your premium option may be rejected and you should call Customer Service at 1-800-378-5234 for another premium option.

When will I get my member materials?

After you enroll, here's what will happen:

- Once Network Health Insurance Corporation verifies your eligibility for enrollment, your enrollment form is sent to the Centers for Medicare and Medicaid Services (CMS), the government agency that monitors the administration of all Medicare plans.
- A welcome letter is sent to you verifying your enrollment.
- We will then send a member kit that includes your Member ID card and details of your health plan benefits.



Grievance and Appeals Process for Network Health Insurance Corporation

YOU HAVE A RIGHT TO APPEAL

You can appeal if you do not agree with Network Health Insurance Corporation's decisions about your health care. You must file your appeal in writing within 60 calendar days after the date of the denial. We can give you more time if you have a good reason for missing the deadline. **You have the right to appeal if you think:**

- Network Health Insurance Corporation will not approve or give you care it should cover.
- Network Health Insurance Corporation is stopping care you still need.
- Network Health Insurance Corporation has denied payment for services or items you have received and are not covered and you think it should be covered.

WHO MAY FILE AN APPEAL?

You or someone you name to act for you (your **authorized representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others also already may be authorized under State law to act for you.

You can call us at: (800) 378-5234 to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/ TDD (800) 947-3529.

If you want someone to act for you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

THERE ARE THREE KINDS OF APPEALS

Standard (30 days) if your request is for medical coverage/services - You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

Standard (60 days) if your request is for payment of services you have received - You can ask for a standard appeal. We must give you a decision no later than 60 days after we get your appeal.

Fast (72 hour review) - You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 30 day.
- We will make a decision on your appeal and notify you of it within 72-hours of receipt of your request. However, if our decision is not fully in your favor, we will automatically forward your appeal request to the CMS contractor (MAXIMUS Federal Services) for an independent review. MAXIMUS will send you a letter with their decision within three working days of receipt of your case from Network Health Insurance Corporation.

SUPPORT FOR YOUR APPEAL

You are not required to submit additional information to support your request for services or payment for services already received.

Network Health Insurance Corporation is responsible for gathering all necessary medical information, however, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your Primary Care Physician. If your medical records from specialist physicians are not included in your medical record from your Primary Care Physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you.

YOU HAVE THE RIGHT TO PRESENT YOUR CASE IN PERSON (The following information applies to both 30-day and 60 day appeals)

Network Health Insurance Corporation will provide an opportunity for you to provide additional information in person or in writing. You or your representative will be notified at least seven (7) business days in advance of the time and date that the Grievance and Appeals Committee will hear your case.

WHAT HAPPENS NEXT?

If you appeal, we will review our decision. After we review our decision, if payment for any of your claims is still denied, we will automatically forward your appeal request to the CMS Contractor (MAXIMUS Federal Services) for an independent review. This is provided by Medicare for a new and impartial review of your case outside of your Medicare Advantage Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.