2023

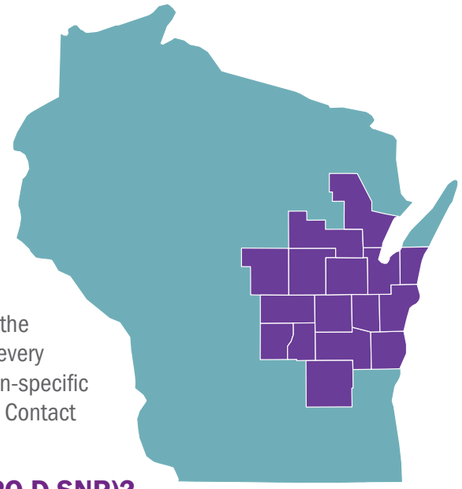

# NetworkCares PPO Dual-Eligible Special Needs Plan (D-SNP)

## Summary of Benefits

# 2023 NETWORK*CARES* (PPO D-SNP)

## SERVICE AREA AND ELIGIBILITY

To be eligible to join Network Health's PPO D-SNP plan described in this booklet, you must be entitled to Medicare Part A, enrolled in Medicare Part B, enrolled in Wisconsin Medicaid and live in the service area. This Summary of Benefits applies to the Network*Cares* plan offered in the following counties in Wisconsin—Brown, Calumet, Dodge, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marquette, Oconto, Outagamie, Portage, Shawano, Sheboygan, Waupaca, Waushara and Winnebago.



## WHAT IS A SUMMARY OF BENEFITS?

This booklet gives you a summary of what we cover and what you pay on the Network*Cares* (PPO D-SNP) plan. It doesn't list every service we cover or every limitation or exclusion. A complete list of services can be found in the plan-specific *Evidence of Coverage* at **networkhealth.com/medicare/plan-materials**. Contact member experience for a printed copy.

## WHAT IS A DUAL-ELIGIBLE SPECIAL NEEDS PLAN (PPO D-SNP)?

This Medicare Advantage plan is specifically designed for people who are eligible for both Medicare and Medicaid (called dual-eligible). How much Medicaid covers depends on your income, resources and other factors. Some people get full Medicaid benefits and some only get help to pay for certain Medicare costs, including premiums, deductibles, coinsurance or copayments.

## CONTACT NETWORK HEALTH

| | |
|---|---|
| **By Phone** | Sales Department – **800-983-7587**<br>Member Experience Team – **855-653-4363**<br>TTY/TDD Users – **800-947-3529** |
| **Online** | **networkhealth.com** |
| **By Mail or In Person** | Network Health<br>1570 Midway Pl.<br>Menasha, WI 54952 |
| **Hours of Operation** | • Normal office hours are Monday–Friday, 8 a.m. to 5 p.m.<br>• Network Health is closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve Day and Christmas Day.<br>• From October 1–March 31, you can call the sales department and the member experience team seven days a week from 8 a.m. to 8 p.m., Central Time. From April 1–September 30, we are available Monday–Friday, from 8 a.m. to 8 p.m., Central Time. |
| **Additional Resources** | **Medicare – Available 24 hours a day, seven days a week**<br>For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, seven days a week. |



# SUMMARY OF BENEFITS

| Your Costs | Network*Cares* (Includes pharmacy) (PPO D-SNP) | Medicaid |
|---|---|---|
| | **YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED)**<br>**If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.** | |
| **Monthly Premium** | $0 | Premiums, deductibles and payment limitations depend on the type of coverage you have. For benefit questions, contact Forward Health Member Services at 800-362-3002 or consult your Forward Health Enrollment and Benefits Handbook. |
| **Annual Medical Deductible** | In 2022 the amounts were:<br>$0-$233 depending on your level of Medicaid eligibility.<br>These amounts may change for 2023. | |
| **Annual Maximum Out-of-Pocket–**<br>(Does not include Part D prescription drugs) | $8,300 for services you receive from in-network providers<br>$12,450 for services you receive from any provider, your limit for services received from in- and out-of-network providers will count toward this limit | |
| **Hospital Services** | | |
| **Inpatient Hospital Services[1]–**<br>Per admission | In 2022 the amounts for each admission were<br>Days 1-60 $0-$1,556 deductible<br>Days 61-90 $0-$389 per day<br>Days 91 and beyond $0-$778 per day<br>(This plan covers 60 lifetime reserve days)<br>These amounts may change for 2023. | Covered |
| **Outpatient Hospital Services** | 0%-20% of the cost | Covered |
| **Ambulatory Surgical Center** | 0%-20% of the cost | Covered |
| **General Services** | | |
| **Primary Care Provider Visit** | 0%-20% of the cost | Covered |
| **Specialist Visit** | 0%-20% of the cost | Covered |
| **Preventive Care** | | |
| **Preventive Care Visits*** | $0 in-network<br>0%-20% of the cost out-of-network | Covered |
| **Annual Medicare Wellness Visit** | $0 in-network<br>0%-20% of the cost out-of-network | Covered |
| **Physician Telehealth Services** | Virtual primary care and urgent care services cost the same as an in-person visit | Covered |
| **Medicare-Covered Vaccines–**<br>Flu, pneumonia, COVID | $0 in-network<br>0% of the cost out-of-network | Covered |
| **Medicare-Covered Vaccines–**<br>Hepatitis B, all other Part B | $0 in-network<br>0%-20% of the cost out-of-network | Covered |

*Includes abdominal aortic aneurysm screening, alcohol misuse screening and counseling, annual wellness visit, bone mass measurement, breast cancer screening, cardiovascular disease screening, cardiovascular disease risk reduction visit, cervical and vaginal cancer screening, colorectal cancer screening (screening colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare Diabetes Prevention Program, obesity screening and therapy, prostate cancer screening, screening for sexually transmitted infections and counseling, smoking and tobacco use cessation counseling, one time Welcome to Medicare preventive visit.

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit.

Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

| Your Costs | Network*Cares* (Includes pharmacy) (PPO D-SNP) | Medicaid |
|---|---|---|
| | YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED)<br>If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost. | |
| **Emergency Care** | | |
| **Emergency Room Visit–**<br>Copayment is waived if admitted to a U.S. hospital within 24 hours | 0%-20% of the cost, up to $95 | Coverage may not be available outside the state of Wisconsin |
| **Urgent Care** | | |
| **Urgent Care Visit–**<br>Free-standing facility | 0%-20% of the cost, up to $60 | Covered |
| **Diagnostic Services** | | |
| **Diagnostic Tests–**<br>Such as ultrasound, EKG, stress test | 0%-20% of the cost | Covered |
| **Labs–**<br>What you pay may be based on the service received and/or where you are treated | 0%-20% of the cost | Covered |
| **Diagnostic Radiology Services–**<br>Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans) | 0%-20% of the cost | Covered |
| **X-rays** | 0%-20% of the cost | Covered |
| **Hearing Services** | | |
| **Routine Hearing Exam**[2] | $0 in-network, or<br>$40 out-of-network | Covered |
| **Diagnostic Hearing Exam–**<br>Exam to diagnose and treat hearing issues | 0%-20% of the cost | Covered |
| **Hearing Aids**[2]**–**<br>Maximum of two hearing aids per year<br>Hearing aid evaluation and fitting included | $495-$1,695 per device, hearing aids must be purchased through the plan's approved partner | Covered |
| **Dental Services** | | |
| **Preventive and Comprehensive Dental Coverage**[2] | $0 Cleaning (twice a year)<br>$0 Dental X-ray(s) (bitewing 1 per year, full mouth 1 every 5 years)<br>$0 Oral Exam (twice a year)<br>$0 Basic Restorative Services<br>50% of the cost for major services (endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery, other services)<br>$3,000 Annual Maximum | Covered |
| **Medicare-Covered Dental Services–**<br>Does not include services in connection with care, treatment, filling, removal or replacement of teeth | 0%-20% of the cost | Covered |

| Your Costs | Network*Cares* (Includes pharmacy) (PPO D-SNP) | Medicaid |
|---|---|---|
| | YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED)<br>If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost. | |
| **Vision Services** | | |
| **Annual Routine Vision Exam**[2] | $0 in-network, or<br>$40 reimbursement out-of-network | Covered |
| **Diagnostic Eye Exam–**<br>To diagnose and treat diseases and conditions of the eye | 0%-20% of the cost | Covered |
| **Post-Cataract Eyewear**[2]**–**<br>One pair of eyeglasses or contact lenses after each cataract surgery | 0%-20% of the cost | Covered |
| **Additional Eyewear**[2]**–**<br>At EyeMed providers | $400 allowance in-network, or<br>$400 reimbursement out-of-network | Covered |
| **Mental Health/Substance Abuse** | | |
| **Outpatient Mental Health–**<br>Individual or group therapy | 0%-20% of the cost | Covered |
| **Inpatient Mental Health**[1]**–**<br>Per admission | In 2022 the amounts for each admission were<br>Days 1-60 $0-$1,556 deductible<br>Days 61-90 $0-$389 per day<br>Days 91 and beyond $0-$778 per day<br>(This plan covers 60 lifetime reserve days)<br>These amounts may change for 2023. | Covered |
| **Opioid Treatment Services** | 0%-20% of the cost | Covered |
| **Substance Abuse Services–**<br>Outpatient individual or group therapy | 0%-20% of the cost | Covered |
| **Continued Care Services** | | |
| **Skilled Nursing Facility**[1]**–**<br>Per admission | In 2022 the amounts were<br>$0 per day, days 1-20<br>$0-$194.50 per day, days 21-100<br>A prior three-day inpatient hospital stay is required.<br>These amounts may change for 2023. | Covered |
| **Outpatient Physical**[1]**, Occupational**[1]**, Speech Therapy** | 0%-20% of the cost | Covered |
| **Home-Based Palliative Care**[1]**–**<br>One palliative care evaluation and two follow up visits | $0 | Not Covered |
| **Transportation Services** | | |
| **Air and Ground Ambulance Services** | 0%-20% of the cost | Covered |

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

| Your Costs | NetworkCares (Includes pharmacy) (PPO D-SNP) | Medicaid |
|---|---|---|
| | YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost. | |
| **Non-Emergency Transportation** | 24 one-way trips, anywhere within the Network Health Medicare Advantage Plan service area. Additionally includes 24 one-way trips for members with ESRD to get to and from dialysis | Covered |
| **Drug Coverage** | | |
| **Medicare Part B Drugs**[1] | 0%-20% of the cost | Covered |
| **Medicare Part D Drugs–** See pages 8-10 for specific drug tier costs | Covered | Covered |
| **Additional Benefits** | | |
| **Over-the-Counter Coverage**[2] | $60 per quarter. No rollover on quarterly allowance. | Limited coverage |
| **Fitness with SilverSneakers®** | Included | Not covered |
| **MDLIVE®Virtual Visit–** Virtual visit for medical | $0 | Not covered |
| **Meal Delivery–** Following a qualified hospital observation stay, inpatient hospital stay or skilled nursing facility stay | 28 meals | Not covered |
| **Wellness Reward** | Earn a $50 health reward by completing your annual health risk assessment | |
| **Travel Coverage** | | |
| **Travel within the United States** | Receive in-network coverage when you venture outside Wisconsin and within the United States and its territories. You can see any provider who accepts Medicare beneficiaries. | Coverage may not be available outside the state of Wisconsin |
| **International Emergency Coverage–** View the Evidence of Coverage for details at networkhealth.com/medicare/plan-materials | $110 per incident<br>$100,000 maximum benefit | Not covered |
| **Recovery and Rehabilitation Services** | | |
| **Durable Medical Equipment–** Such as insulin pumps[1], CPAP machines[1], prosthetic devices[1] | 0%-20% of the cost | Covered |
| **Chiropractic Services–** Manipulation of the spine to correct misalignment of one or more of the bones of your spine | 0%-20% of the cost | Covered |
| **Medicare-Covered Acupuncture–** For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year | 0%-20% of the cost | Covered |
| **Medicare-Covered Home Health Care Visits**[1] | $0 | Covered |
| **Cancer Services** | | |
| **Chemotherapy**[1] | 0%-20% of the cost | Covered |
| **Radiation Therapy**[1]**–** Per service | 0%-20% of the cost | Covered |
| **Acupuncture–** Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting | $0 | Not covered |
| **Diabetic Services** | | |
| **Diabetes Monitoring Supplies and Test Strips–** OneTouch™ and Accu-Chek™ test strips<br>Continuous Glucose Monitoring supplies limited to FreeStyle Libre® and Dexcom® obtained through your pharmacy<br>All other brands are not covered | 0%-20% of the cost | Covered – One Touch<br>Not covered – Accu-Chek |
| **Diabetic Shoe Inserts–** Copayment per pair | 0%-20% of the cost | Covered |
| **Diabetes Management Tool** | 0%-20% of the cost | Not covered |
| **End-Stage Renal Disease** | | |
| **Dialysis–** Per treatment | 0%-20% of the cost | Covered |

# PRESCRIPTION DRUG BENEFITS

| Your Drug Costs | NetworkCares (Includes pharmacy) (PPO D-SNP) | Medicaid |
|---|---|---|
| **How much do I pay?** | For Part B drugs such as chemotherapy drugs[1]<br>• In- and out-of-network 0%-20% of the cost<br>Other Part B drugs[1]<br>• In- and out-of-network 0%-20% of the cost<br>Part D Prescription Drug Deductible on Tier 1 $0, Tiers 2-5 $505 | Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs |

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

## Your Drug Costs

INITIAL COVERAGE **PREFERRED RETAIL** COST-SHARING

After you reach your yearly deductible of $0-$505 for your Tier 2 - 5 drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

| Tier | One-month supply<br>For generic drugs (including brand drugs treated as generic), either: | Three-month supply<br>For generic drugs (including brand drugs treated as generic), either: |
|---|---|---|
| **Tier 1 (Preferred Generics)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $7 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $17 or 15% of the cost |
| **Tier 2 (Generics and Non-Preferred Generics)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $12 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $30 or 15% of the cost |
| **Tier 3 (Non-Preferred Generics and Preferred Brands)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $42 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $105 or 15% of the cost |
| **Tier 4 (Non-Preferred Generics and Non-Preferred Brands)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $95 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $237 or 15% of the cost |
| **Tier 5 (Specialty)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or 15% of the cost | Not offered |





## Your Drug Costs

INITIAL COVERAGE **STANDARD RETAIL** COST-SHARING

After you reach your yearly deductible of $0-$505 for your Tier 2 - 5 drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

| Tier | One-month supply<br>For generic drugs (including brand drugs treated as generic), either: | Three-month supply<br>For generic drugs (including brand drugs treated as generic), either: |
|---|---|---|
| **Tier 1 (Preferred Generics)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $10 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $25 or 15% of the cost |
| **Tier 2 (Generics and Non-Preferred Generics)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $19 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $47 or 15% of the cost |
| **Tier 3 (Non-Preferred Generics and Preferred Brands)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $47 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $117 or 15% of the cost |
| **Tier 4 (Non-Preferred Generics and Non-Preferred Brands)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $100 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $250 or 15% of the cost |
| **Tier 5 (Specialty)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or 15% of the cost | Not offered |

## Your Drug Costs

**INITIAL COVERAGE MAIL ORDER RETAIL COST-SHARING**

After you reach your yearly deductible of $0-$505 for your Tier 2 - 5 drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

| Tier | One-month supply<br>For generic drugs (including brand drugs treated as generic), either: | Three-month supply<br>For generic drugs (including brand drugs treated as generic), either: |
|---|---|---|
| **Tier 1 (Preferred Generics)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $7 or 15% of the cost | • $0 copayment for 31-90 day mail order |
| **Tier 2 (Generics and Non-Preferred Generics)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment; or lesser of $12 or 15% of the cost | • $0 copayment for 31-90 day mail order |
| **Tier 3 (Non-Preferred Generics and Preferred Brands)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $42 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $105 or 15% of the cost |
| **Tier 4 (Non-Preferred Generics and Non-Preferred Brands)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $95 or 15% of the cost | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or lesser of $237 or 15% of the cost |
| **Tier 5 (Specialty)** | • $0 copayment; or<br>• $1.45 copayment; or<br>• $4.15 copayment<br>For all other drugs, either:<br>• $0 copayment; or<br>• $4.30 copayment; or<br>• $10.35 copayment; or 15% of the cost | Not offered |

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. If it is necessary to use an out-of-network pharmacy, please check first with customer service because you may pay more than you pay at an in-network pharmacy.

**COVERAGE GAP**

You enter the coverage gap when your total drug costs reach $4,660. You pay 25% and Network Health pays 75% for generic drugs. For brand name drugs, you pay 25%, Network Health pays 5% and the drug company pays 70%. If you are receiving "Extra Help" the coverage gap may not apply.

**CATASTROPHIC COVERAGE**

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,400, you pay $0-$4.15 for drugs treated as generic and $0-$10.35 for drugs treated as brand.





Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a member experience representative at **855-653-4363** (TTY 800-947-3529), Monday–Friday from 8 a.m. to 8 p.m. From October 1–March 31, we're available every day from 8 a.m. to 8 p.m.

### Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **networkhealth.com/medicare/plan-materials** or call **855-653-4363** (TTY 800-947-3529) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

### Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2024.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services received by non-contracted providers.
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

# NOTES

# NOTES

## Multi-Language Insert – REQUIRED INFORMATION

### Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 800-378-5234 (TTY 800-947-3529). Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 800-378-5234 (TTY 800-947-3529). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 800-378-5234 (TTY 800-947-3529)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 800-378-5234 (TTY 800-947-3529)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 800-378-5234 (TTY 800-947-3529). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 800-378-5234 (TTY 800-947-3529). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 800-378-5234 (TTY 800-947-3529) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 800-378-5234 (TTY 800-947-3529). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 800-378-5234 (TTY 800-947-3529) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.



**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 5234-378-800 (TTY 3529-947-800). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 800-378-5234 (TTY 800-947-3529) . سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 800-378-5234 (TTY 800-947-3529) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 800-378-5234 (TTY 800-947-3529). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 800-378-5234 (TTY 800-947-3529). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 800-378-5234 (TTY 800-947-3529). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 800-378-5234 (TTY 800-947-3529). Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、800-378-5234 (TTY 800-947-3529) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

**Hmong:** Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog peb li kev noj qab hauv huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais kws txhais lus pab dawb, tsuas yog hu rau peb ntawm tus xov tooj 800-378-5234 (TTY 800-947-3529). Qee tus neeg uas hais Askiv/Yam Lus koj paub tuaj yeem pab tau rau koj. Qhov no yog kev pab dawb.


800-983-7587
TTY 800-947-3529
networkhealth.com

Network*Cares* is a PPO D-SNP plan with a Medicare contract and a contract with the Wisconsin Medicaid program. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal. This plan is available to anyone who has both Medical Assistance from the State and Medicare. Out-of-network/non-contracted providers are under no obligation to treat Network Health members, except in emergency situations. Please call our member experience number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.
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# NOTICE OF UPDATE

Please reference the details found below regarding important information related to changes in Medicare Advantage coverage, as a result of the Inflation Reduction Act (IRA) enacted on August 16, 2022. These updates impact Medicare Part B prescription drug coverage and Medicare Part B insulin coverage. Here is a quick summary of the updates.

1. Beginning April 1, 2023, the Centers for Medicare & Medicaid Services (CMS) is starting a new Inflation Rebate Program impacting certain Part B drugs.

   This new drug law requires drug companies to pay a rebate if they raise their prices for certain drugs faster than the rate of inflation. You may see lower out-of-pocket costs for certain Part B drugs and biologics with prices that have increased faster than the rate of inflation. For these drugs and biologicals, your coinsurance will be 0-20 percent of the inflation-adjusted payment amount, which will be less than what you would pay in coinsurance otherwise.

2. Beginning July 1, 2023, you may see lower out-of-pocket costs for insulin delivered by an item of durable medical equipment. You will also not pay more than $35 for a one-month supply of each insulin product covered by your plan.

| Where you can find the current language in the 2023 Annual Notice of Change | Original information | Updated information | What does this mean for you? |
|---|---|---|---|
| Section 3, Administrative Changes | There was no administrative change listed for Medicare Part B prescription drug or Part B insulin changes. | 0-20% of the cost for each Medicare-covered Part B and chemotherapy drug.<br><br>Effective April 1, 2023, Part B rebatable drugs will not exceed the coinsurance amount of the original Medicare adjusted coinsurance for the Part B rebatable drug.<br><br>Effective July 1, 2023, a $35 copayment for a one-month supply of Part B insulin. | Starting April 1, 2023, some Part B rebatable drugs may result in a lower coinsurance of 0-20%.<br><br>Starting July 1, 2023, for Part B insulin you will not pay more than a $35 copayment for a one-month supply. |