Network Health Cares (PPO D-SNP) offered by Network Health Insurance Corporation

Annual Notice of Changes for 2024

You are currently enrolled as a member of Network*Cares*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at networkhealth.com. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you. You may also call our member experience team to ask us to mail you an *Evidence of Coverage*.

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

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3. **CHOOSE:** Decide whether you want to change your plan
    - If you don't join another plan by December 7, 2023, you will stay in Network Health Cares.
    - To **change to a different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with Network Health Cares.
    - Look in Section 5, page 18 to learn more about your choices.
    - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Our member experience team has free language interpreter services available for non-English speakers (phone numbers are in Section 9.1 of this document).
- Please contact our member experience team at 855-653-4363 for additional information. (TTY users should call 800-947-3529), Monday – Friday from 8 a.m. to 8 p.m. From October 1, 2023 through March 31, 2024, we are available every day from 8 a.m. to 8 p.m. This call is free.
- This information is available for free in other formats.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Network Health Cares

- Network Health Medicare Advantage plans include PPO and MSA plans. Network Health 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.
- When this document says "we," "us," or "our", it means Network Health Insurance Corporation. When it says "plan" or "our plan," it means Network Health Cares.

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Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for Network Health Cares in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 3.1 for details.	$0	$0
Deductible	In 2022, the annual Part B deductible was $0 or $233. These amounts may change for 2023. If you are eligible for Medicare cost sharing assistance under Medicaid, you pay $0.	In 2023, the annual Part B deductible was $0 or $226. except for insulin furnished through an item of durable medical equipment. These amounts may change for 2024. If you are eligible for Medicare cost sharing assistance under Medicaid, you pay $0.
Doctor office visits	**In- and Out-of-Network** Primary care visits: 0% - 20% per visit Specialist visits: 0% - 20% per visit If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit.	**In- and Out-of-Network** Primary care visits: 0% - 20% per visit Specialist visits: 0% - 20% per visit If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital stays	**In- and Out-of-Network** In 2022, the amounts for each benefit period were $0 or up to: • Days 1-60: $1,556 deductible+ • Days 61-90: $389 per day+ • Days 91-140: $778 per lifetime reserve day+ +These amounts may change for 2023. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.	**In- and Out-of-Network** In 2023, the amounts for each benefit period were $0 or up to: • Days 1-60: $1,600 deductible+ • Days 61-90: $400 per day+ • Days 91-140: $800 per lifetime reserve day+ +These amounts may change for 2024. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 3.5 for details.)	Deductible: $505 except for covered insulin products and most adult Part D vaccines. Copayment/coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0, $1.45, $4.15, $7 or 15% at a preferred pharmacy and $0, $1.45, $4.15, $10 or 15% at a standard pharmacy. • Drug Tier 2: $0, $1.45, $4.15, $12 or 15% at a preferred pharmacy and $0, $1.45, $4.15, $19 or 15% at a standard pharmacy. • Drug Tier 3: $0, $1.45, $4.15, $4.30, $10.35, $42 or 15% at a preferred pharmacy and $0, $1.45, $4.15, $4.30, $10.35, $47 or 15% at a standard pharmacy. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $0, $1.45, $4.15, $4.30, $10.35, $95 or 15% at a preferred pharmacy and $0, $1.45, $4.15, $4.30, $10.35, $100 or 15% at a standard pharmacy. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: $0, $1.45, $4.15, $4.30, $10.35, 15% or 25% at both preferred and standard pharmacies. Catastrophic Coverage: For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	Deductible: $545 except for covered insulin products and most adult Part D vaccines. Copayment/coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0, $1.55, $4.50 or $7 at a preferred pharmacy and $0, $1.55, $4.50 or $15 at a standard pharmacy. • Drug Tier 2: $0, $1.55, $4.50 or $13 at a preferred pharmacy and $0, $1.55, $4.50 or $20 at a standard pharmacy. • Drug Tier 3: $0, $1.55, $4.50, $4.60, $11.20 or $42 at a preferred pharmacy and $0, $1.55, $4.50, $4.60, $11.20 or $47 at a standard pharmacy. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $0, $1.55, $4.50, $4.60, $11.20 or $95 at a preferred pharmacy and $0, $1.55, $4.50, $4.60, $11.20 or $100 at a standard pharmacy. You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: $0, $1.55, $4.50, $4.60, $11.20 or 25% at both preferred and standard pharmacies. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 3.2 for details.)	From in-network providers: $8,300 From in-network and out-of-network providers combined: $12,450 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From in-network providers: $8,300 From in-network and out-of-network providers combined: $12,450 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

SECTION 1 We Are Changing the Plan's Name

On January 1, 2024, our plan name will change from Network*Cares* to Network Health Cares.

You will receive your ID card for plan year 2024 in October, and it will contain your new plan name. You may begin using this ID card for services you receive on January 1, 2024.

If you elect to change your plan during the annual enrollment period, you will receive a new ID card that reflects your new plan, which should be used for services you receive beginning January 1, 2024.

SECTION 2 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Network Health Cares in 2024

If you do nothing in 2023, we will automatically enroll you in our Network Health Cares. This means starting January 1, 2024, you will be getting your medical and prescription drug coverage through Network Health Cares. If you want to change plans or switch to Original Medicare and get your prescription drug coverage through a Prescription Drug Plan you must do so between October 15 and December 7. The change will take effect on January 1, 2024.

SECTION 3 Changes to Benefits and Costs for Next Year

Section 3.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

Section 3.2 – Changes to Your Maximum Out-of-Pocket Amount

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copayments and deductibles, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copayments) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	**In-Network** $8,300 Once you have paid $8,300 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. **Combined In- and Out-of-Network** $12,450 Once you have paid $12,450 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	**In-Network** $8,300 Once you have paid $8,300 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. **Combined In- and Out-of-Network** $12,450 Once you have paid $12,450 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Section 3.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at networkhealth.com. You may also call our member experience team for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 *Pharmacy Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are a part of your plan during the year. If a mid-year change in our providers affects you, please contact our member experience team so we may assist.

Section 3.4 – Changes to Benefits and Costs for Medical Services

Please note that the *Annual Notice of Changes* tells you about changes to your Medicare benefits and costs.

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Note that beginning July 2023, cost-sharing for insulin furnished through an item of DME is subject to a coinsurance cap of $35 for one-month's supply of insulin.

Cost	2023 (this year)	2024 (next year)
Dental Services	**In-and-Out-of-Network** You pay 0% of the cost for preventive and basic dental services. You pay 50% of the cost for major dental services.	Annual maximum of $3,000 combined for preventive and comprehensive dental services. **In- Network** You pay 0% of the cost for preventive and basic dental services. You pay 0% of the cost for major dental services. **Out-of-Network** You pay 0% of the cost for preventive and basic dental services. You pay 50% of the cost for major dental services.
Emergency care	**In- and Out-of-Network** You pay 0% - 20% of the cost (up to $95) for each Medicare-covered emergency room visit within the United States and its territories.	**In- and Out-of-Network** You pay 0% - 20% of the cost (up to $100) for each Medicare-covered emergency room visit within the United States and its territories.
Fresh produce or pantry box delivery benefit	Fresh produce or pantry box delivery is not covered.	Network Health Cares members that work with a care manager and have been diagnosed with diabetes, congestive heart failure or obesity may be eligible to receive produce or pantry boxes for delivery, up to six boxes per calendar year. **In-Network** You pay **0%** of the cost of home-delivered food boxes. **Out-of-Network** Boxes must be provided by the plan's approved partner. We do not reimburse for home-delivered boxes provided by other services.

Cost	2023 (this year)	2024 (next year)
Help with certain chronic conditions – Palliative care	**In- and Out-of-Network** You pay a $0 copayment for each home- or office-based palliative care visit. Note: This benefit includes one initial consultation and evaluation, and two follow-up visits.	**In- and Out-of-Network** Home- or office-based palliative care visits are not covered.
In-Home support services	In-Home support services not covered.	In-home support offers transportation to and from medical appointments, assistance with errands, grocery shopping and support with everyday tasks such as light cleaning, meal prep, pet care and more. Additional help with computer, smartphone and tablet technology which can include social media, accessing a telehealth provider or health plan resources and starting video chats. Support either in-home or via telephone. **In-Network** You pay **0%** of the cost of in-home support services. **Out-of-Network** Services must be provided by the plan's approved partner. We do not reimburse in-home support services provided by other providers.

Cost	2023 (this year)	2024 (next year)
Inpatient hospital care	**Per admission** **In- and Out-of-Network** In 2022 the amounts for each admission were $0 or up to: • Days 1-60: $1,556 deductible+ • Days 61-90: $389 per day+ • Days 91-150: $778 per lifetime reserve day+ You will not be charged additional cost sharing for professional services. + These amounts may change for 2023. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.	**Per admission** **In- and Out-of-Network** In 2023 the amounts for each admission were $0 or up to: • Days 1-60: $1,600 deductible+ • Days 61-90: $400 per day+ • Days 91-140: $800 per lifetime reserve day+ You will not be charged additional cost sharing for professional services. + These amounts may change for 2024. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.
Inpatient services in a psychiatric hospital	**Per Admission** **In- and Out-of-Network** In 2022 the amounts for each admission were $0 or up to: • Days 1-60: $1,556 deductible+ • Days 61-90: $389 per day+ • Days 91-150: $778 per lifetime reserve day+ + These amounts may change for 2023. You will not be charged additional cost sharing for professional services. Lifetime reserve days can only be used once.	**Per Admission** **In- and Out-of-Network** In 2023 the amounts for each admission were $0 or up to: • Days 1-60: $1,600 deductible+ • Days 61-90: $400 per day+ • Days 91-140: $800 per lifetime reserve day+ + These amounts may change for 2024. You will not be charged additional cost sharing for professional services. Lifetime reserve days can only be used once.

Cost	2023 (this year)	2024 (next year)
Medicare Part B prescription drugs	**In- and Out-of-Network** You pay 0% - 20% of the cost for each Medicare-covered Part B and chemotherapy drug	**In- and Out-of-Network** You pay 0% - 20% of the cost for each Medicare-covered Part B and chemotherapy drug. Part B rebatable drugs will not exceed the coinsurance amount of the original Medicare adjusted coinsurance for the Part B rebatable drug. Insulin cost sharing is the lesser of 20% or $35 per one-month supply.
Over-the-counter (OTC) items	Our plan offers a $60 quarterly allowance, to be used to purchase qualified over-the-counter (OTC) items from our mail-order service. **In-Network** You pay 0% of the cost of qualified OTC items, up to the $60 quarterly maximum.	Our plan offers a $175 quarterly allowance, to be used to purchase qualified over-the-counter (OTC) items from our mail-order service. **In-Network** You pay 0% of the cost of qualified OTC items, up to the $175 quarterly maximum.
Skilled nursing facility (SNF) care	**Per admission** **In- and Out-of-Network** In 2022, the amounts for each admission after at least a 3-day covered hospital stay were $0 or up to: • Days 1-20: $0 per day+ • Days 21-100: $194.50 per day+ You will not be charged additional cost sharing for professional services. + These amounts may change for 2023. You are covered for up to 100 days per admission.	**Per admission** **In- and Out-of-Network** In 2023, the amounts for each admission were $0 or up to: • Days 1-20: $0 per day+ • Days 21-100: $200 per day+ You will not be charged additional cost sharing for professional services. + These amounts may change for 2024. You are covered for up to 100 days per admission.

Cost	2023 (this year)	2024 (next year)
Transportation benefit (non-emergency)	Your plan covers 24 one-way trips per year to and from approved locations within the plan's service area. **In-Network** You pay 0% of the cost of eligible trips.	Your plan covers 36 one-way trips per year to and from approved locations within the plan's service area. **In-Network** You pay 0% of the cost of eligible trips.
Urgently needed services	**In- and Out-of-Network** You pay 0% - 20% of the cost (up to $60) for each Medicare-covered urgently needed care visit within the United States and its territories.	**In- and Out-of-Network** You pay 0% - 20% of the cost (up to $55) for each Medicare-covered urgently needed care visit within the United States and its territories.

Section 3.5 – Changes to Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically. **You can get the *complete* Drug List** by calling our member experience team (see the back cover) or visiting our website networkhealth.com/look-up-medications.

We made changes to our Drug List which could include removing or adding drugs changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up-to-date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your *Evidence of Coverage* and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact our member experience team for more information.

Changes to Prescription Drug Costs

If you receive Extra Help to pay your Medicare prescription drugs, you may qualify for a reduction or elimination of your cost sharing for Part D drugs. Some of the information described in this section may not apply to you. **Note:** If you are in a program that helps pay for your drugs (Extra Help), **the information about costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs (also called the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call our member experience team and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your*:* Tier 2, Tier 3, Tier 4 and Tier 5 Part D drugs until you have reached the yearly deductible. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.	Your deductible amount is either $104 or $505, depending on the level of "Extra Help" you receive. (Look at the separate insert, the "LIS Rider," for your deductible amount.)	The deductible is $545. During this stage, you pay $0, $1.55, $4.50, $7, $15 cost sharing for drugs on Tier 1 and the full cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage Once you pay the yearly deductible, you move to the Initial Coverage Stage. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at an in-network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply at an in-network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $0, $1.45, $4.15 or $10 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.45, $4.15 or $7 per prescription or 15% of the total cost. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $0, $1.45, $4.15 or $19 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.45, $4.15 or $12 per prescription or 15% of the total cost. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.45, $4.15, $4.30, $10.35 or $47 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.45, $4.15, $4.30, $10.35 or $42 per prescription or 15% of the total cost. **Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $0, $1.45, $4.15, $4.30, $10.35 or $100 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.45, $4.15, $4.30, $10.35 or $95 per prescription or 15% of the total cost.	Your cost for a one-month supply at an in-network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $0, $1.55, $4.50 or $15 per prescription. *Preferred cost sharing:* You pay $0, $1.55, $4.50 or $7 per prescription. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $0, $1.55, $4.50 or $20 per prescription. *Preferred cost sharing:* You pay $0, $1.55, $4.50 or $13 per prescription. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.55, $4.50, $4.60, $11.20 or $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay $0, $1.55, $4.50, $4.60, $11.20 or $42 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $$0, $1.55, $4.50, $4.60, $11.20 or $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. *Preferred cost sharing:* You pay $0, $1.55, $4.50, $4.60, $11.20 or $95 per prescription. You pay $35 per month supply of each covered insulin product on this tier.

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay $0, $1.45, $4.15, $4.30 or $10.35 per prescription or 15% or 25% of the total cost. *Preferred cost sharing:* You pay $0, $1.45, $4.15, $4.30, $10.35 per prescription or 15% or 25% or of the total cost. **Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).**	**Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay $0, $1.55, $4.50, $4.60, $11.20 per prescription or 25% of the total cost. *Preferred cost sharing:* You pay $0, $1.55, $4.50, $4.60, $11.20 per prescription or 25% or of the total cost. **Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).**

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage.*

SECTION 4 Administrative Changes

Description	2023 (this year)	2024 (next year)
Tier 1 3-Month Supply	90-day supply	100-day supply
Prior authorization requirements	No prior authorization required for spine surgery or peripheral vascular disease.	Prior authorization required for spine surgery and peripheral vascular disease.

SECTION 5 Deciding Which Plan to Choose

Section 5.1 – If you want to stay in Network Health Cares

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in Network Health Cares.

Section 5.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 7), or call Medicare (see Section 9.2).

As a reminder, Network Health Insurance Corporation offers other Medicare health plans. These other plans may differ in coverage, monthly premiums and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from Network Health Cares.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Network Health Cares.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact our member experience team if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

If you switch to Original Medicare and do **not** enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan unless you have opted out of automatic enrollment.

SECTION 6 Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get Extra Help paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 7 Programs That Offer Free Counseling about Medicare and Medicaid

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Wisconsin, the SHIP is called Wisconsin SHIP.

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. Wisconsin SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Wisconsin SHIP at 800-242-1060. You can learn more about Wisconsin SHIP by visiting their website at www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm.

For questions about your Wisconsin Medicaid benefits, contact Wisconsin Medicaid at 800-362-3002, Monday – Friday from 8 a.m. to 6 p.m. TTY users should call 711. Ask how joining another plan or returning to Original Medicare affects how you get your Wisconsin Medicaid coverage.

SECTION 8 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **Extra Help from Medicare.** Because you have Medicaid, you are already enrolled in Extra Help, also called the Low-Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, seven days a week.
  - The Social Security Office at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
  - Your State Medicaid Office (applications).
- **Help from your state's pharmaceutical assistance program.** Wisconsin has a program called Wisconsin Senior Care that helps people pay for prescription drugs based on their financial need, age, or medical condition. To learn more about the program, check with your State Health Insurance Assistance Program.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Wisconsin AIDS/HIV Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 608-261-6952, 608-267-6875 or 800-991-5532.

SECTION 9 Questions?

Section 9.1 – Getting Help from Network Health Cares

Questions? We're here to help. Please call our member experience team at 855-653-4363. (TTY only, call 800-947-3529.) We are available for phone calls Monday – Friday from 8 a.m. to 8 p.m. From October 1, 2023 through March 31, 2024, we are available every day from 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your *2024 Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2024. For details, look in the *2024 Evidence of Coverage* for Network Health Cares. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at networkhealth.com/medicare/plan-materials. You may also call our member experience team to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at networkhealth.com. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (*Formulary/Drug List*).

Section 9.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.Medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Section 9.3 – Getting Help from Medicaid

To get information from Medicaid you can call Wisconsin Medicaid at 800-362-3002. TTY users should call 711.

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.