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

Annual Notice of Changes for 2022

You are currently enrolled as a member of Network*Cares*. Next year, there will be some changes to the plan's costs and benefits. *This booklet tells about the changes.*

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.

- It's important to review your coverage now to make sure it will meet your needs next year.
- Do the changes affect the services you use?
- Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

☐ Check the changes in the booklet to our prescription drug coverage to see if they affect you.

- Will your drugs be covered?
- Are your drugs in a different tier, with different cost sharing?
- Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?
- Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?
- Review the 2022 *Drug List* and look in Section 1.6 for information about changes to our drug coverage.
- Your drug costs may have risen since last year. Talk to your doctor about lower cost alternatives that may be available for you; this may save you in annual out-of-pocket costs throughout the year. To get additional information on drug prices visit go.medicare.gov/drugprices, and click the "dashboards" link in the middle of the second Note toward the bottom of the page. These dashboards highlight which manufacturers have been increasing their prices and also show other year-to-year drug price information. Keep in mind that your plan benefits will determine exactly how much your own drug costs may change.

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☐ Check to see if your doctors and other providers will be in our network next year.

- Are your doctors, including specialists you see regularly, in our network?
- What about the hospitals or other providers you use?
- Look in Section 1.3 for information about our *Provider Directory*.

☐ Think about your overall health care costs.

- How much will you spend out-of-pocket for the services and prescription drugs you use regularly?
- How much will you spend on your premium and deductibles?
- How do your total plan costs compare to other Medicare coverage options?

☐ 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 personalized search feature on the Medicare Plan Finder at www.medicare.gov/plan-compare website.
- Review the list in the back of your *Medicare & You 2022* handbook.
- Look in Section 3.2 to learn more about your choices.

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

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2021, you will be enrolled in Network*Cares*.
- If you want to **change to a different plan** that may better meet your needs, you can switch plans between October 15 and December 7. Look in section 3.2, page 18 to learn more about your choices.

4. **ENROLL:** To change plans, join a plan between **October 15** and **December 7, 2021**

- If you don't join another plan by **December 7, 2021**, you will be enrolled in Network*Cares*.
- If you join another plan between **October 15** and **December 7, 2021**, your new coverage will start on **January 1, 2022**. You will be automatically disenrolled from your current plan.

Additional Resources

- Our member experience team has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This information is available for free in other formats. For more information, please contact our member experience team at 855-653-4363 (TTY 800-947-3529), Monday - Friday from 8 a.m. to 8 p.m. From October 1, 2021 through March 31, 2022, we are available every day from 8 a.m. to 8 p.m.
- **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*Cares*

- Network Health Medicare Advantage plans include PPO, MSA and HMO plans. 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.
- When this booklet says "we," "us," or "our," it means *Network Health Insurance Corporation*. When it says "plan" or "our plan," it means Networ*kCares*.

Summary of Important Costs for 2022

The table below compares the 2021 costs and 2022 costs for Network*Cares* in several important areas. **Please note this is only a summary of changes**. 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*.

Cost	2021 (this year)	2022 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	In 2020, the annual Part B deductible was $0 or $198. These amounts may change for 2021. If you are eligible for Medicare cost sharing assistance under Medicaid, you pay $0.	In 2021, the annual Part B deductible was $0 or $203. These amounts may change for 2022. If you are eligible for Medicare cost sharing assistance under Medicaid, you pay $0.
Doctor office visits	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.	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	2021 (this year)	2022 (next year)
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day**.**	**In-Network** In 2020, the amounts for each benefit period were $0 or up to: • Days 1-60: $1,408 deductible + • Days 61-90: $352 per day+ • Days 91-150: $704 per lifetime reserve day+ **Out-of-Network** In 2020, the amounts for each benefit period were $0 or up to: • Days 1-60: $1,408 deductible+ • Days 61-90 $352 per day+ • Days 91-150: $704 per lifetime reserve day+ +These amounts may change for 2021. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.	**In-Network** In 2021, the amounts for each benefit period were $0 or up to: • Days 1-60: $1,484 deductible + • Days 61-90: $371 per day+ • Days 91-150: $742 per lifetime reserve day+ **Out-of-Network** In 2021, the amounts for each benefit period were $0 or up to: • Days 1-60: $1,484 deductible+ • Days 61-90 $371 per day+ • Days 91-150: $742 per lifetime reserve day+ +These amounts may change for 2022. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.

Cost	2021 (this year)	2022 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $445 Copayment/coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0, $1.30, $3.70, $4, or 15% at a preferred pharmacy and $0, $1.30, $3.70, $6 or 15% at a standard pharmacy. • Drug Tier 2: $0, $1.30, $3.70, $8 or 15% at a preferred pharmacy and $0, $1.30, $3.70, $14 or 15% at a standard pharmacy. • Drug Tier 3: $0, $1.30, $3.70, $4, $9.20, $42 or 15% at a preferred pharmacy and $0, $1.30, $3.70, $4, $9.20, $47 or 15% at a standard pharmacy. • Drug Tier 4: $0, $1.30, $3.70, $4, $9.20, $90 or 15% at a preferred pharmacy and $0, $1.30, $3.70, $4, $9.20, $100 or 15% at a standard pharmacy. • Drug Tier 5: $0, $1.30, $3.70, $4, $9.20, 15% or 25% at both preferred and standard pharmacies.	Deductible: $480 Copayment/coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0, $1.35, $3.95, $5 or 15% at a preferred pharmacy and $0, $1.35, $3.95, $8 or 15%at a standard pharmacy. • Drug Tier 2: $0, $1.35, $3.95, $10 or 15% at a preferred pharmacy and $0, $1.35, $3.95, $17 or 15%at a standard pharmacy. • Drug Tier 3: $0, $1.35, $3.95, $4, $9.85, $42 or 15% at a preferred pharmacy and $0, $1.35, $3.95, $4, $9.85, $47 or 15%at a standard pharmacy. • Drug Tier 4: $0, $1.35, $3.95, $4, $9.85, $95 or 15% at a preferred pharmacy and $0, $1.35, $3.95, $4, $9.85, $100 or 15% at a standard pharmacy. • Drug Tier 5: $0, $1.35, $3.95, $4, $9.85, 15% or 25% at both preferred and standard pharmacies.
Maximum out-of-pocket amount This is the <u>most</u> you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From in-network providers: $6,700 From in-network and out-of-network providers combined: $10,000 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: $6,700 From in-network and out-of-network providers combined: $10,000 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.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2021 (this year)	2022 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	No change

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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.

Cost	2021 (this year)	2022 (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.	$6,700 Once you have paid $6,700 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.	No change

Cost	2021 (this year)	2022 (next year)
Combined in and out-of-network maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. Your costs for covered medical services (such as copayments and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$10,000 Once you have paid $10,000 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.	No change

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated *Provider Directory* is located on our website at networkhealth.com/provider-resources/printable-directory. You may also call our member experience team for updated provider information or to ask us to mail you a *Provider Directory*. **Please review the 2022 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we must furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our in-network pharmacies. Our network includes pharmacies with preferred cost sharing, which may offer you lower cost sharing than the standard cost sharing offered by other in-network pharmacies for some drugs.

There are changes to our network of pharmacies for next year. An updated *Pharmacy Directory* is located on our website at networkhealth.com/find-a-pharmacy. You may also call our member experience team for updated provider information or to ask us to mail you a *Pharmacy Directory*. **Please review the 2022 *Pharmacy Directory* to see which pharmacies are in our network**.

Section 1.5 – 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 changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2022 Evidence of Coverage.* 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*.

Opioid treatment program services

Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

Cost	2021 (this year)	2022 (next year)
Chiropractic services	**Out of Network** No prior authorization required	**Out of Network** Requires prior authorization
Emergency Care	**In-Network** You pay 0% - 20% of the cost (up to $90) for Medicare-covered emergency room visits. You pay $90 per incident for each non-Medicare covered emergency room visit outside the United States and its territories. **Out-of-Network** You pay 0% - 20% of the cost (up to $90) for Medicare-covered emergency room visits. You pay $90 per incident for each non-Medicare covered emergency room visit outside the United States and its territories. **If you are admitted as an inpatient within 24 hours for the same condition, you pay $0 for the emergency room visit.**	**In-Network** You pay 0% - 20% of the cost (up to $90) for Medicare-covered emergency room visits. You pay $90 per incident for each non-Medicare covered emergency room visit outside the United States and its territories. **Out-of-Network** You pay 0% - 20% of the cost (up to $90) for Medicare-covered emergency room visits. **You pay** $90 per incident for each non-Medicare covered emergency room visit outside the United States and its territories. **Your cost share is not waived when you are admitted as an inpatient within 24 hours for the same condition.**

Cost	2021 (this year)	2022 (next year)
Hearing services – additional benefits	Qualifying hearing aids from a participating provider are discounted to **$795 - $2,370** per hearing aid. Non-Medicare covered routine hearing exams not covered.	**In-Network** You pay **$679 - $2,299** copayment per hearing aid. You pay **$0** copayment for each non-Medicare covered routine hearing exam. **Out-of-Network** You pay **$679 - $2,299** copayment per hearing aid. Hearing aids must be purchased through our in-network partner. You pay **$40** copayment for a non-Medicare covered routine hearing exam.
Help with Certain Chronic Conditions – Palliative Care	**In-Network** You pay a $0 copayment for one home-based palliative care consultation and evaluation for members with an end-stage (stage 4) cancer diagnosis. **Out-of-Network** You pay a $0 copayment for one home-based palliative care consultation and evaluation for members with an end-stage (stage 4) cancer diagnosis.	**In-Network** You pay a $0 copayment for one home-based palliative care consultation and evaluation and up to two follow up home-based palliative care visits for members with cancer. **Out-of-Network** You pay a $0 copayment for one home-based palliative care consultation and evaluation and up to two follow up home-based palliative care visits for members with cancer.
Home health Services	**Out-of-Network** No prior authorization required	**Out-of-Network** Requires prior authorization

Cost	2021 (this year)	2022 (next year)
Inpatient hospital care	**Per admission** **In-Network** In 2020 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,408 deductible + 2. Days 61-90: $352 per day + 3. Days 91-150: $704 per lifetime reserve day. + You will not be charged additional cost sharing for professional services. **Out-of-Network** In 2020 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,408 deductible + 2. Days 61-90: $352 per day + 3. Days 91-150: $704 per lifetime reserve day. + + These amounts may change for 2021. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.	**Per admission** **In-Network** In 2021 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,484 deductible + 2. Days 61-90: $371 per day + 3. Days 91-150: $742 per lifetime reserve day. + You will not be charged additional cost sharing for professional services. **Out-of-Network** In 2021 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,484 deductible + 2. Days 61-90: $371 per day + 3. Days 91-150: $742 per lifetime reserve day. + + These amounts may change for 2022. If you are eligible for Medicare cost-sharing assistance under Medicaid, you may pay $0.

Cost	2021 (this year)	2022 (next year)
Inpatient mental health care	**Per Admission** **In-Network** In 2020 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,408 deductible + 2. Days 61-90: $352 per day. + 3. Days 91-190: $704 per lifetime reserve day. + + These amounts may change for 2021. You will not be charged additional cost sharing for professional services. **Out-of-Network** In 2020 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,408 deductible + 2. Days 61-90: $352 per day + 3. Days 91-150: $704 per lifetime reserve day. +These amounts may change for 2021. You will not be charged additional cost sharing for professional services. Lifetime reserve days can only be used once.	**Per Admission** **In-Network** In 2021 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,484 deductible + 2. Days 61-90: $371 per day. + 3. Days 91-190: $742 per lifetime reserve day. + + These amounts may change for 2022. You will not be charged additional cost sharing for professional services. **Out-of-Network** In 2021 the amounts for each admission were $0 or up to: 1. Days 1-60: $1,484 deductible + 2. Days 61-90: $371 per day + 3. Days 91-150: $742 per lifetime reserve day. +These amounts may change for 2022. You will not be charged additional cost sharing for professional services. Lifetime reserve days can only be used once.
Occupational therapy services	**Out of Network** No prior authorization required	**Out of Network** Requires prior authorization

Cost	2021 (this year)	2022 (next year)
Over-the-counter (OTC) items	Our plan offers a **$150** quarterly allowance, to be used to purchase qualified over-the-counter (OTC) items from our mail order service. Maximum of one order per quarter. **In-Network** You pay 0% of the cost of qualified OTC items, up to the **$150** quarterly maximum. **Out-of-Network** OTC items must be ordered from the plan’s approved service. We do not reimburse for OTC items purchased from retail stores or other mail order services.	Our plan offers a **$155** quarterly allowance, to be used to purchase qualified over-the-counter (OTC) items from our mail order service. Maximum of one order per quarter. **In-Network** You pay 0% of the cost of qualified OTC items, up to the **$155** quarterly maximum. **Out-of-Network** OTC items must be ordered from the plan’s approved service. We do not reimburse for OTC items purchased from retail stores or other mail order services.
Physician Specialist services excluding Psychiatric Services	**Out-of-Network** No prior authorization required	**Out-of-Network** Requires prior authorization
Podiatry Services	**Out-of-Network** No prior authorization required	**Out-of-Network** Requires prior authorization

Cost	2021 (this year)	2022 (next year)
Skilled nursing facility (SNF) care	**Per admission** **In-Network** In 2020, the amounts for each admission after at least a 3-day covered hospital stay were $0 or up to: 1. Days 1-20: $0 per day + 2. Days 21-100: $176 per day + You will not be charged additional cost sharing for professional services. **Out-of-Network** In 2020, the amounts for each admission after at least a 3-day covered hospital stay were $0 or up to: 1. Days 1-20: $0 per day + 2. Days 21-100: $176 per day + + These amounts may change for 2021. You are covered for up to 100 days per admission.	**Per admission** **In-Network** In 2021, the amounts for each admission after at least a 3-day covered hospital stay were $0 or up to: 1. Days 1-20: $0 per day + 2. Days 21-100: $185.50 per day + You will not be charged additional cost sharing for professional services. **Out-of-Network** In 2021, the amounts for each admission after at least a 3-day covered hospital stay were $0 or up to: 1. Days 1-20: $0 per day + 2. Days 21-100: $185.50 per day + + These amounts may change for 2022. You are covered for up to 100 days per admission.
Telemonitoring for members diagnosed with chronic and congestive heart failure – to monitor and manage symptoms, adherence to diet and medications, optimal fluid status and daily physical activity.	**In-Network** You pay **0%** of the cost for non-Medicare covered telemonitoring. **Out-of-Network** You pay **50%** of the cost for non-Medicare covered telemonitoring.	Not covered Virtual visits and other telehealth services continue to be covered in 2022.

Section 1.6 – 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 at networkhealth.com/look-up-medications.

We made changes to our *Drug List*, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the *Drug List* to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug.
  - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) or call our member experience team.
- **Work with your doctor (or prescriber) to find a different drug** that we cover. You can call our member experience team to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a temporary supply of a non-formulary drug in the first 90 days of the plan year or the first 90 days of membership to avoid a gap in therapy. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you are a member of our plan and receive a tiering exception or a formulary exception for a drug not on our *Drug List*, the drug will remain covered under the exception through the end of the calendar year. You will need to submit a new request next year if you wish to continue receiving the drug under an exception.

If you are a member of our plan and receive a formulary exception to remove a restriction on coverage for a drug, the drug will remain covered based on the original expiration date of the exception. The exception may expire before the end of the year or may carry over into next year. You will need to submit a new request when the original exception expires if you wish to continue receiving the drug under an exception

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.

When we make these changes to the *Drug List* during the year, you can still work with your doctor (or other prescriber) and ask us to make an exception to cover the drug. We will also continue to update our online *Drug List* as scheduled and provide other required information to reflect drug changes. (To learn more about the changes we may make to the *Drug List*, see Chapter 5, Section 6 of the *Evidence of Coverage*.)

Changes to Prescription Drug Costs

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 haven’t received this insert by September 30, 2021 please call our member experience team and ask for the “LIS Rider.”

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year 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. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*, which 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*.)

Changes to the Deductible Stage

Stage	2021 (this year)	2022 (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 is $445	The deductible is $480

Changes to Your Cost sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs* in your *Evidence of Coverage*.

Stage	2021 (this year)	2022 (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** 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 filled at an in-network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $0, $1.30, $3.70 or $6 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.30, $3.70 or $4 per prescription or 15% of the total cost. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $0, $1.30, $3.70 or $14 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.30, $3.70 or $8 per prescription or 15% of the total cost. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.30, $3.70, $4, $9.20 or $47 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.30, $3.70, $4, $9.20 or $42 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, $1.35, $3.95 or $8 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.35, $3.95 or $5 per prescription or 15% of the total cost. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $0, $1.35, $3.95 or $17 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.35, $3.95 or $10 per prescription or 15% of the total cost. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.35, $3.95, $4, $9.85or $47 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.35, $3.95, $4, $9.85 or $42 per prescription or 15% of the total cost.

Stage	2021 (this year)	2022 (next year)
Stage 2: Initial Coverage Stage (continued)	**Tier 4 Non-Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.30, $3.70, $4, $9.20 or $100 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.30, $3.70, $4, $9.20 or $90 per prescription or 15% of the total cost. **Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay $0, $1.30, $3.70, $4 or $9.20 per prescription or 15% or 25% of the total cost. *Preferred cost sharing:* You pay $0, $1.30, $3.70, $4 or $9.20 per prescription or 15% or 25% of the total cost. **Once your total drug costs have reached $4,130, you will move to the next stage (the Coverage Gap Stage).**	**Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $0, $1.35, $3.95, $4, $9.85 or $100 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.35, $3.95, $4, $9.85 or $95 per prescription or 15% of the total cost. **Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay $0, $1.35, $3.95, $4 or $9.85 per prescription or 15% or 25% of the total cost. *Preferred cost sharing:* You pay $0, $1.35, $3.95, $4, $9.85 per prescription or 15% or 25% or of the total cost. **Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage).**

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Administrative Changes

Cost	2021 (this year)	2022 (next year)
$0 for a 31-90 day supply of drugs through Express Scripts Home Delivery, after you reach your deductible.	Available for Tier 1 drugs	Available for Tier 1 **and Tier 2** drugs To view a full list of covered drugs, visit networkhealth.com/look-up-medications.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Network*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 our plan Network*Cares*.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2022 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, read the *Medicare & You 2022* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to www.medicare.gov/plan-compare. **Here, you can find information about costs, coverage and quality ratings for Medicare plans.**

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*Cares*.

- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Network*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 this (phone numbers are in Section 7.1 of this booklet).
  - – *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 4 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from **October 15** until **December 7**. The change will take effect on January 1, 2022.

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

In certain situations, changes are also allowed at other times of the year. For example, 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 may be allowed to make a change at other times of the year.

If you enrolled in a Medicare Advantage plan for January 1, 2022, 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, 2022. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

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

The Wisconsin SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. 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 The Board on Aging and Long Term Care at 800-242-1060. You can learn more about Wisconsin SHIP by visiting their website at https://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 6 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 Monday – Friday from 8 a.m. and 7 p.m. TTY users should call, 1-800-325-0778 (applications); 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 (the name and phone numbers for this organization are in Section 5 of this booklet).
- **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 608-267-6875 or 800-991-5532.

SECTION 7 Questions?

Section 7.1 – Getting Help from Network*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. Calls to these numbers are free.

Read your 2022 *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 2022. For details, look in the 2022 *Evidence of Coverage* for Network*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 7.2 – 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

You can visit the Medicare website (www.medicare.gov). It has information about cost, coverage and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to www.medicare.gov/plan-compare.)

Read *Medicare & You 2022*

You can read the *Medicare & You 2022* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) 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 7.3 – Getting Help from Medicaid

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