Network Platinum*Select* (PPO) offered by Network Health Insurance Corporation

Annual Notice of Changes for 2023

You are currently enrolled as a member of Network Platinum*Select*. 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*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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 2023 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 2023* handbook.

☐ 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, 2022, you will stay in Network Platinum*Select*.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023.** This will end your enrollment with Network Platinum*Select*.
- 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 8.1 of this document).
- Please contact our member experience team at 800-378-5234 for additional information. (TTY users should call 800-947-3529), Monday - Friday from 8 a.m. to 8 p.m. From October 1, 2022 through March 31, 2023, we are available every day from 8 a.m. to 8 p.m.
- 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 Platinum*Select*

- Network Health Medicare Advantage Plans include MSA, PPO and HMO plans with a Medicare contract. 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 Platinum*Select*.

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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Network Platinum*Select* in several important areas. **Please note this is only a summary of costs**.

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 2.1 for details.	$0	$0
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)	From in-network providers: $4,900 From in-network and out-of-network providers combined: $4,900	From in-network providers: $4,250 From in-network and out-of-network providers combined: $4,250
Doctor office visits	**In- and Out-of-Network** Primary care visits: $0 per visit Specialist visits: $50 per visit	**In- and Out-of-Network** Primary care visits: $0 per visit Specialist visits: $50 per visit
Inpatient hospital stays	**In- and Out-of-Network** $335 copayment per day for days 1-6 of a Medicare-covered inpatient hospital stay, for each admission. $0 copayment per day for all other days of a Medicare-covered stay in a hospital, for each admission.	**In- and Out-of-Network** $335 copayment per day for days 1-6 of a Medicare-covered inpatient hospital stay, for each admission. $0 copayment per day for all other days of a Medicare-covered stay in a hospital, for each admission.

Cost	2022 (this year)	2023 (next year)
Part D prescription drug coverage (See Section 2.5 for details.)	Deductible: $395 Deductible applies to Tiers 4 and 5 Copayment/coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $2 at a preferred pharmacy and $5 at a standard pharmacy. • Drug Tier 2: $8 at a preferred pharmacy and $15 at a standard pharmacy. • Drug Tier 3: $42 at a preferred pharmacy and $47 at a standard pharmacy. • Drug Tier 4: $95 at a preferred pharmacy and $100 at a standard pharmacy. • Drug Tier 5: 25% at both preferred and standard pharmacies.	Deductible: $395 Deductible applies to Tiers 4 and 5 Copayment/coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $2 at a preferred pharmacy and $5 at a standard pharmacy. • Drug Tier 2: $8 at a preferred pharmacy and $15 at a standard pharmacy. • Drug Tier 3: $42 at a preferred pharmacy and $47 at a standard pharmacy. • Drug Tier 4: $95 at a preferred pharmacy and $100 at a standard pharmacy. • Drug Tier 5: 26% at both preferred and standard pharmacies.

SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in Network Platinum*Select* in 2023

If you do nothing by December 7, 2022, we will automatically enroll you in our Network Platinum*Select*. This means starting January 1, 2023, you will be getting your medical and prescription drug coverage through Network Platinum*Select*. If you want to change plans or switch to Original Medicare, you must do so between October 15 and December 7. If you are eligible for "Extra Help," you may be able to change plans during other times.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0
Dental Optional Supplemental Benefit premium	$39	$39

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amounts

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

Cost	2022 (this year)	2023 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network providers count toward your in-network maximum out-of-pocket amount. Your costs for Part D prescription drugs do not count toward your maximum out-of-pocket amount.	$4,900 Once you have paid $4,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.	$4,250 Once you have paid $4,250 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network providers for the rest of the calendar year.

Cost	2022 (this year)	2023 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your costs for outpatient Part D prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$4,900 Once you have paid $4,900 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.	$4,250 Once you have paid $4,250 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from in-network or out-of-network providers for the rest of the calendar year.

Section 2.3 – 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.

There are changes to our network of providers for next year. **Please review the 2023 *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 2023 *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 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 2.4 – Changes to Benefits and Costs for Medical Services

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

Cost	2022 (this year)	2023 (next year)
Cardiac rehabilitation services	**In- and Out-of-Network** You pay a **$25** copayment for each Medicare-covered cardiac rehabilitation or intensive cardiac rehabilitation.	**In- and Out-of-Network** You pay a **$20** copayment for each Medicare-covered cardiac rehabilitation or intensive cardiac rehabilitation.

Cost	2022 (this year)	2023 (next year)
Emergency care	**Per admission** **In- and Out-of-Network** You pay a $90 copayment for each Medicare-covered emergency room visit within the United States and its territories. You pay a $90 per incident for each non-Medicare covered emergency room visit outside the United States and its territories.	**Per admission** **In- and Out-of-Network** You pay a $110 copayment for each Medicare-covered emergency room visit within the United States and its territories. You pay a $110 per incident for each non-Medicare covered emergency room visit outside the United States and its territories.
Hearing services – extra benefits	**In-Network** You pay a **$679 - $2,299** copayment per hearing aid. **Out-of-Network** You pay a **$679 - $2,299** copayment per hearing aid. Hearing aids must be purchased through our in-network partner.	**In-Network** You pay a **$495 – $1,695** copayment per hearing aid. **Out-of-Network** You pay a **$495 - $1,695** copayment per hearing aid. Hearing aids must be purchased through the plan's approved partner.
Help with certain chronic conditions – Palliative care	**In- and Out-of-Network** You pay a $0 copayment for each home-based palliative care visit for members with cancer. Note: This benefit includes one initial consultation and evaluation, and two follow-up visits.	**In- and Out-of-Network** You pay a $0 copayment for each home or office-based palliative care visit for members with cancer, congestive heart failure, chronic obstructive pulmonary disease, chronic kidney disease, end-stage renal disease, rheumatoid arthritis, Alzheimer’s, Parkinson’s, multiple sclerosis and/or liver cirrhosis. Note: This benefit includes one initial consultation and evaluation, and two follow-up visits.
Pick Your Perks reimbursement program	Expenses must be submitted by March 31, 2023, or within 90 days of disenrollment with the plan.	Reimbursement must be postmarked within 120 days of the purchase/service date.

Cost	2022 (this year)	2023 (next year)
Pulmonary rehabilitation services	**In- and Out-of-Network** You pay a **$25** copayment for each Medicare-covered pulmonary rehabilitation service.	**In- and Out-of-Network** You pay a **$20** copayment for each Medicare-covered pulmonary rehabilitation service.
Skilled nursing facility (SNF) care	**Per admission** **In- and Out-of-Network** You pay a $0 copayment per day for days 1-20 of a Medicare-covered skilled nursing facility stays. You pay a $188 copayment per day for days 21-50 of a Medicare-covered skilled nursing facility stay. You pay a $0 copayment per day for days 51-100 of a Medicare-covered skilled nursing facility stay.	**Per admission** **In- and Out-of-Network** You pay a $0 copayment per day, days 1-20 of a Medicare-covered skilled nursing facility stay. You pay a $196 copayment per day, days 21-45 of a Medicare-covered skilled nursing facility stay. You pay a $0 copayment per day, days 46-100 of a Medicare-covered skilled nursing facility stay.
Supervised Exercise Therapy (SET)	**In- and Out-of-Network** You pay a **$25** copayment for each Medicare-covered supervised exercise therapy session.	**In- and Out-of-Network** You pay a **$20** copayment for each Medicare-covered supervised exercise therapy session.
Urgently needed services – worldwide coverage	**Per admission** **In- and Out-of-Network** You pay a $90 per incident for each non-Medicare covered urgently needed care visit outside the United States and its territories.	**Per admission** **In- and Out-of-Network** You pay a $110 per incident for each non-Medicare covered urgently needed care visit outside the United States and its territories.

Section 2.5 – 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, 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.**

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

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, 2022, 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.)

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you. Call our member experience team for more information.

Important Message About What You Pay for Insulin - You won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 4 and Tier 5 drugs until you have reached the yearly deductible.	The deductible is $395. During this stage, you pay $2 at a preferred pharmacy or $5 at a standard pharmacy for drugs on Tier 1, $8 at a preferred pharmacy or $15 at a standard pharmacy for drugs on Tier 2, $42 at a preferred pharmacy or $47 at a standard pharmacy for drugs on Tier 3 and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible.	The deductible is $395. During this stage, you pay $2 at a preferred pharmacy or $5 at a standard pharmacy for drugs on Tier 1, $8 at a preferred pharmacy or $15 at a standard pharmacy for drugs on Tier 2, $42 at a preferred pharmacy or $47 at a standard pharmacy for drugs on Tier 3 and the full cost of drugs on Tier 4 and Tier 5 until you have reached the yearly deductible.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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 at an in-network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $5 per prescription. *Preferred cost sharing:* You pay $2 per prescription. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $8 per prescription. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $42 per prescription. **Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay 25% of the total cost. *Preferred cost sharing:* You pay 25% of the total cost. **Once your total drug costs have reached $4,430, you will move to the next stage (the Coverage Gap Stage)**.	Your cost for a one-month supply at an in-network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $5 per prescription. *Preferred cost sharing:* You pay $2 per prescription. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $15 per prescription. *Preferred cost sharing:* You pay $8 per prescription. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $47 per prescription. *Preferred cost sharing:* You pay $42 per prescription. **Tier 4 Non-Preferred Drugs:** *Standard cost sharing:* You pay $100 per prescription. *Preferred cost sharing:* You pay $95 per prescription. **Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay 26% of the total cost. *Preferred cost sharing:* You pay 26% of the total cost. **Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage)**.

SECTION 3 Administrative Changes

Description	2022 (this year)	2023 (next year)
Pharmacy Network	The 2022 pharmacy network is a broad network.	The 2023 pharmacy network is a narrow network. The pharmacy you are currently utilizing may no longer be in-network or may have changed from a preferred pharmacy to a standard pharmacy. Please look up your pharmacy by visiting networkhealth.com/find-a-pharmacy or call our member experience to see if there is a change to your pharmacy's status.
Pick your Perks reimbursement submission	Expenses must be submitted by March 31, 2023.	Reimbursement requests must be postmarked within 120 days of the purchase/service date.

SECTION 4 Deciding Which Plan to Choose

Section 4.1 – If you want to stay in Network Platinum*Select*

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 Network Platinum*Select.*

Section 4.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2023 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. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

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 2023* handbook, call your State Health Insurance Assistance Program (see Section 6), or call Medicare (see Section 8.2).

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 Platinum*Select*.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Network Platinum*Select*.
- 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.

SECTION 5 Deadline for 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, 2023.

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.

If you enrolled in a Medicare Advantage Plan for January 1, 2023, 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, 2023.

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 6 Programs That Offer Free Counseling about Medicare

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 https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm.

SECTION 7 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.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75 percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, 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 608-267-6875 or 800-991-5532.

SECTION 8 Questions?

Section 8.1 – Getting Help from Network Platinum*Select*

Questions? We're here to help. Please call our member experience team at 800-378-5234. (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, 2022 through March 31, 2023, we are available every day from 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your *2023 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 2023. For details, look in the *2023 Evidence of Coverage* for Network Platinum*Select.* 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 8.2 – 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 2023*

Read the *Medicare & You 2023* handbook. Every 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 document, you can get it at the Medicare website (https://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.

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.

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 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.	20% of the cost for each Medicare-covered Part B and chemotherapy drug. 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. 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 20%. Starting July 1, 2023, for Part B insulin you will not pay more than a $35 copayment for a one-month supply.