network health

Network Platinum*Plus* Pharmacy (PPO) offered by Network Health Insurance Corporation

Annual Notice of Changes for 2020

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

- **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.

- 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 2020 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 https://go.medicare.gov/drugprices. 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.

☐ 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 https://www.medicare.gov website. Click "Find health & drug plans."
- Review the list in the back of your Medicare & You 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 want to **keep** Network Platinum*Plus* Pharmacy, you don't need to do anything. You will stay in Network Platinum*Plus* Pharmacy.
- To change to a **different plan** that may better meet your needs, you can switch plans between October 15 and December 7.

4. ENROLL: To change plans, join a plan between **October 15** and **December 7, 2019**

- If you don't join another plan by **December 7, 2019**, you will stay in Network Platinum*Plus* Pharmacy.
- If you join another plan by **December 7, 2019**, your new coverage will start on **January 1, 2020**.

Additional Resources

- Customer service 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 customer service at 800-378-5234, Monday through Friday, 8 a.m. to 8 p.m. TTY users should call 800-947-3529, if you need information in another format. From October 1, 2019 through March 31, 2020, 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 https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About Network Platinum*Plus* Pharmacy

- 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 booklet says "we," "us," or "our," it means Network Health Insurance Corporation. When it says "plan" or "our plan," it means Network Platinum*Plus* Pharmacy.

Summary of Important Costs for 2020

The table below compares the 2019 costs and 2020 costs for Network Platinum*Plus* Pharmacy 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 customer service to ask us to mail you an *Evidence of Coverage*.

Cost	2019 (this year)	2020 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$122	$123
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 1.2 for details.)	From in-network providers: $3,400 From in-network and out-of-network providers combined: $3,400	From in-network providers: $3,400 From in-network and out-of-network providers combined: $3,400
Doctor office visits	**In-Network** Primary care visits: $15 per visit Specialist visits: $40 per visit **Out-of-Network** Primary care visits: $15 per visit Specialist visits: $40 per visit	**In-Network** Primary care visits: $15 per visit Specialist visits: $40 per visit **Out-of-Network** Primary care visits: $15 per visit Specialist visits: $40 per visit

Cost	2019 (this year)	2020 (next year)
Inpatient hospital stays 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** $375 copay per day for days 1-5 of a Medicare covered stay in a hospital. $0 copay for days 5 and beyond of a Medicare covered stay in a hospital. Additional days covered. **Out-of-Network** $375 copay per day for days 1-4 of a Medicare covered stay in a hospital. $0 copay for days 5 and beyond of a Medicare covered stay in a hospital. Additional days covered.	**In-Network** $175 copay per day for days 1-5 of a Medicare covered inpatient hospital stay, for each admission. $0 copay per day for all other days of a Medicare covered stay in a hospital, for each admission. **Out-of-Network** $175 copay per day for days 1-5 of a Medicare covered inpatient hospital stay, for each admission. $0 copay per day for all other days of a Medicare covered inpatient hospital stay, for each admission.

Cost	2019 (this year)	2020 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $260 Deductible applies to Tiers 3, 4 and 5 Copayment/Coinsurance as applicable during the Initial Coverage Stage: • Drug Tier 1: $2 at a preferred pharmacy and $4 at a standard pharmacy. • Drug Tier 2: $8 at a preferred pharmacy and $14 at a standard pharmacy. • Drug Tier 3: $42 at a preferred pharmacy and $47 at a standard pharmacy. • Drug Tier 4: $84 at a preferred pharmacy and $91 at a standard pharmacy. • Drug Tier 5: 28% at both preferred and standard pharmacies.	Deductible: $260 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 $4 at a standard pharmacy. • Drug Tier 2: $8 at a preferred pharmacy and $14 at a standard pharmacy. • Drug Tier 3: $42 at a preferred pharmacy and $47 at a standard pharmacy. • Drug Tier 4: $84 at a preferred pharmacy and $91 at a standard pharmacy. • Drug Tier 5: 28% at both preferred and standard pharmacies.

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2019 (this year)	2020 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$122	$123
Dental Optional Supplemental Benefit premium	$35	$37

- 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.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

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

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during 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	2019 (this year)	2020 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,400 Once you have paid $3,400 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.	No change

Cost	2019 (this year)	2020 (next year)
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium does not count toward your maximum out-of-pocket amount.	$3,400 Once you have paid $3,400 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.	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/medicare/plan-materials. You may also call customer service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2020 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 and managing 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/medicare/plan-materials. You may also call customer service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2020 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

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, *Medical Benefits Chart (what is covered and what you pay)*, in your *2020 Evidence of Coverage.* A copy of the *Evidence of Coverage* is located on our website at networkhealth.com/medicare/plan-materials.

Cost	2019 (this year)	2020 (next year)
Dental services – additional benefits	**Out-of-Network** You pay **100%** of the total cost for non-Medicare covered preventive dental services.	**Out-of-Network** Reimbursement up to a maximum of **$100** for one non-Medicare covered oral exam and cleaning.
Emergency care	**In-Network** You pay **25%** of the total cost for each non-Medicare covered Emergency room visit outside of the U.S. and its territories. **Out-of-Network** You pay **25%** of the total cost for each non-Medicare covered Emergency room visit outside of the U.S. and its territories.	**In-Network** **$90** per incident for each non-Medicare covered emergency room visit outside of the United States and its territories. **Out-of-Network** **$90** per incident for each non-Medicare covered emergency room visit outside of the United States and its territories.

Cost	2019 (this year)	2020 (next year)
Inpatient hospital care	**In-Network** You pay a **$375** copay per day for days 1-5 for a Medicare covered stay in a hospital. You pay a **$0** copay per day for all other days of a Medicare covered stay in a hospital. Additional days are covered. **Out-of-Network** You pay a **$375** copay per day for days 1-5 of a Medicare covered stay in a hospital. You pay a **$0** copay per day for all other days of a Medicare covered stay in a hospital. Additional days are covered.	**Per Admission you pay** **In-Network** You pay a **$175** copay per day for days 1-5 of a Medicare covered inpatient hospital stay. You pay a **$0** copay per day for all other days of a Medicare covered stay in a hospital. **Out-of-Network** You pay a **$175** copay per day for days 1-5 of a Medicare covered inpatient hospital stay. You pay a **$0** copay per day for all other days of a Medicare covered stay in a hospital.
Inpatient mental health care	**In-Network** You pay a **$150** copay per day for days 1-10 for Medicare covered inpatient psychiatric stay. You pay a **$0** copay per day for days 11-90 for Medicare covered inpatient psychiatric stay including lifetime reserve days. Lifetime reserve days may only be used once. **Out-of-Network** You pay a **$150** copay per day for days 1-10 for a Medicare covered inpatient psychiatric stay. You pay a **$0** copay per day for days 11-90 for Medicare covered inpatient psychiatric stay including lifetime reserve days. Lifetime reserve days may only be used once.	**Per Admission you pay** **In-Network** You pay a **$150** copay per day for days 1-10 of a Medicare covered inpatient psychiatric stay. You pay a **$0** copay per day for days 11-90 of a Medicare covered inpatient psychiatric stay, including lifetime reserve days. Lifetime reserve days can only be used once. **Out-of-Network** You pay a **$150** copay per day for days 1-10 of a Medicare covered inpatient psychiatric stay. You pay a **$0** copay per day for days 11-90 of a Medicare covered inpatient psychiatric stay, including lifetime reserve days. Lifetime reserve days can only be used once.

Cost	2019 (this year)	2020 (next year)
Opioid treatment program services	Opioid treatment program services are not covered.	**In-Network** You pay a **$35** copay for each Medicare covered opioid treatment program service. **Out-of-Network** You pay a **$35** copay for each Medicare covered opioid treatment program service.
Over-the-counter (OTC) items	Over-the-counter items are not covered.	Our plan offers a $50 allowance per quarter, to be used to purchase qualified over-the-counter (OTC) items from our mail-order service. One order per quarter. **In-Network** **0%** of the cost of qualified OTC items, up to the $50 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.

Cost	2019 (this year)	2020 (next year)
Skilled nursing facility (SNF) care	**In-Network** You pay a **$20** copay per day for days 1-20 of a Medicare covered skilled nursing facility stay. You pay a **$172** copay per day for days 21-54 of a Medicare covered skilled nursing facility stay. You pay a **$0** copay per day for days 55-100 of a Medicare covered skilled nursing facility stay. **Out-of-Network** You pay a **$20** copay per day for days 1-20 of a Medicare covered skilled nursing facility stay. You pay a **$172** copay per day for days 21-54 of a Medicare covered skilled nursing facility stay. You pay a **$0** copay per day for days 55-100 of a Medicare covered skilled nursing facility stay. Plan covers up to 100 days each benefit period.	**Per Admission you pay** **In-Network** You pay a **$20** copay per day, days 1-20 for Medicare covered skilled nursing facility stay. You pay a **$178** copay per day, days 21-54 for Medicare covered skilled nursing facility stay. You pay a **$0** copay per day, days 55-100 for a Medicare covered skilled nursing facility stay. **Out-of-Network** You pay a **$20** copay per day, days 1-20 for Medicare covered skilled nursing facility stay. You pay a **$178** copay per day, days 21-54 for Medicare covered skilled nursing facility stay. You pay a **$0** copay per day, days 55-100 for a Medicare covered skilled nursing facility stay. You are covered for up to 100 days per admission.
Urgently needed services	**In-Network** You pay **25%** of the total cost for each non-Medicare covered Emergency room visit outside of the U.S. and its territories. **Out-of-Network** You pay a **25%** of the total cost for each non-Medicare covered Emergency room visit outside of the U.S. and its territories.	**In-Network** **$90** per incident for each non-Medicare covered emergency room visit outside of the United States and its territories. **Out-of-Network** **$90** per incident for each non-Medicare covered emergency room visit outside of the United States and its territories.
Vision care – additional benefits	**Out-of-Network** Reimbursement of up to a maximum of **$30** for each non-Medicare covered routine eye exam.	**Out-of-Network** Reimbursement of up to a maximum of **$40** for each non-Medicare covered routine eye exam.

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 customer service (see the back cover) or visiting our website (networkhealth.com/medicare/plan-materials).

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 customer service.
- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call customer service 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 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, 2019 please call customer service and ask for the "LIS Rider." Phone numbers for customer service are in Section 7.1 of this booklet.

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 customer service to ask us to mail you an *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2019 (this year)	2020 (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 $260. During this stage, you pay $2 at a preferred pharmacy or $4 at a standard pharmacy for drugs on Tier 1, $8 at a preferred pharmacy or $14 at a standard pharmacy for drugs on Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5 until you have reached the yearly deductible.	The deductible is $260. During this stage, you pay $2 at a preferred pharmacy or $4 at a standard pharmacy for drugs on Tier 1, $8 at a preferred pharmacy or $14 at a standard pharmacy for drugs on Tier 2, $42 at a preferred pharmacy and $47 at a standard pharmacy 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

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	2019 (this year)	2020 (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 $4 per prescription. *Preferred cost-sharing:* You pay $2 per prescription. **Tier 2 Generic Drugs:** *Standard cost-sharing:* You pay $14 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 Brand Drugs:** *Standard cost sharing:* You pay $91 per prescription. *Preferred cost sharing:* You pay $84 per prescription. **Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay 28% of the total cost. *Preferred cost sharing:* You pay 28% of the total cost. **Once your total drug costs have reached $3,820 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 $4 per prescription. *Preferred cost-sharing:* You pay $2 per prescription. **Tier 2 Generic Drugs:** *Standard cost-sharing:* You pay $14 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 Brand Drugs:** *Standard cost sharing:* You pay $91 per prescription. *Preferred cost sharing:* You pay $84 per prescription. **Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay 28% of the total cost. *Preferred cost sharing:* You pay 28% of the total cost. **Once your total drug costs have reached $4,020 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**. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Process	2019 (this year)	2020 (next year)
Drugs that are on Tier 3 will no longer require deductible be met before copayment applies.	Deductible then copayment	$42 at a preferred pharmacy or $47 at a standard pharmacy.
Certain Part B medications and Part B chemotherapy will require an alternative medication before the requested medication will be covered (Step Therapy).	No Step Therapy requirement	Step Therapy requirement on certain Part B medications and Part B chemotherapy.
Caregiver Support	Caregiver support is <u>not</u> covered.	Our trained Care Managers can provide support and local resources for you as a caregiver and for your authorized representatives. Call 866-709-0019 for more information.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Network Platinum*Plus* Pharmacy

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 stay enrolled as a member of our plan for 2020.

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 2020 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan timely,
- – *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, read *Medicare & You 2020*, 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 https://www.medicare.gov and click "Find health & drug plans." **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 Platinum*Plus* Pharmacy.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Network Platinum*Plus* Pharmacy.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact customer service 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, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 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, 2020.

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. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage.*

If you enrolled in a Medicare Advantage Plan for January 1, 2020, 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, 2020. For more information, see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Wisconsin, the SHIP is called The Board on Aging and Long Term Care.

The Board on Aging and Long Term Care 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. The Board on Aging and Long Term Care 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 The Board on Aging and Long Term Care by visiting their website (http://longtermcare.wi.gov).

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.** 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. Many people are eligible and don't even know it. 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/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. 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 Platinum*Plus* Pharmacy

Questions? We're here to help. Please call customer service at 800-378-5234. (TTY only, call 800-947-3529.) We are available for phone calls Monday through Friday, 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2020 *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 2020. For details, look in the 2020 *Evidence of Coverage* for Network Platinum*Plus* Pharmacy. 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 customer service to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at networkhealth.com/medicare/plan-materials. 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, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

You can visit the Medicare website (https://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 https://www.medicare.gov and click on "Find health & drug plans.")

Read *Medicare & You 2020*

You can read *Medicare & You 2020* 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 (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

REQUIRED INFORMATION - Nondiscrimination

Network Health complies with applicable Federal civil rights laws, conscience and anti-discrimination laws and prohibiting exclusion, adverse treatment, coercion or other discrimination against individuals or entities on the basis of their religious beliefs or moral convictions and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. You may have the right under federal law to decline to undergo certain health care-related treatments, research, or services that violate your conscience, religious beliefs, or moral convictions.

Network Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Network Health's discrimination complaints coordinator at 800-378-5234 (TTY 800-947-3529).

If you believe that Network Health has failed to provide these services, has failed to accommodate your conscientious, religious or moral objection or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Network Health's discrimination complaints coordinator, 1570 Midway Place, Menasha, WI 54952, phone number 800-378-5234, TTY 800-947-3529, Fax 920-720-1907, compliance@networkhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's discrimination complaints coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language Interpreter Services

If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-378-5234 (TTY 800-947-3529).

Albanian: Nëse ju, ose dikush që po ndihmoni, ka pyetje për Network Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 800-378-5234 (TTY 800-947-3529).

Arabic:

إذا كان لديك أو لدى شخص كنت مساعدة، أسئلة حول Health Network، لديك الحق في الحصول على المساعدة والمعلومات باللغة الخاصة بك دون أي تكلفة. للتحدث مع مترجم فوري، قم باستدعاء 800-378-5234 (TTY 800-947-3529).

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Network Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 800-378-5234 (TTY 800-947-3529).

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Network Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-378-5234 (TTY 800-947-3529).

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Network Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-378-5234 (TTY 800-947-3529) an.

Hindi: यदि आप, या किसी को आप की मदद कर रहे हैं, के बारे में सवाल है Network Health, आप कोई भी कीमत पर अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिया के लिए बात करने के लिए, 800-378-5234 (TTY 800-947-3529) कहते हैं।.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-378-5234 (TTY 800-947-3529).

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Network Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-378-5234 (TTY 800-947-3529).로 전화하십시오.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມຄໍາຖາມກ່ຽວກັບ Network Health, ທ່ານມ ສິດທ່ ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 800-378-5234 (TTY 800-947-3529).

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Network Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800-378-5234 (TTY 800-947-3529) uffrufe.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Network Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800-378-5234 (TTY 800-947-3529).

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Network Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-378-5234 (TTY 800-947-3529).

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-378-5234 (TTY 800-947-3529).

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Network Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-378-5234 (TTY 800-947-3529).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Network Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-378-5234 (TTY 800-947-3529).