network health

NetworkCares PPO D-SNP

Summary of Benefits

2021

Medicare Advantage Plan

GOING ABOVE AND BEYOND

2021 NETWORK*CARES* SUMMARY OF BENEFITS

SERVICE AREA AND ELIGIBILITY

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

WHAT IS A SUMMARY OF BENEFITS?

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

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

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

CONTACT NETWORK HEALTH

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

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.**	
Monthly Premium	$0	Premiums, deductibles and payment limitations depend on the type of coverage you have. For benefit questions, contact Forward Health Member Services at 800-362-3002 or consult your Forward Health Enrollment and Benefits Handbook.
Annual Medical Deductible	In 2020 the amounts were: $0-$198 depending on your level of Medicaid eligibility. These amounts may change for 2021.	
Annual Maximum Out-of-Pocket (Does not include prescription drugs)	$6,700 for services you receive from in-network providers $10,000 for services you receive from any provider, your limit for services received from in-network providers will count toward this limit	
Inpatient Hospital[1] Per admission	Annual Medical Deductible $0-$1,408 In 2020 the amounts were: $0 per day, Days 1-60 $0-$352 per day, Days 61-90 $0-$704 per day, Days 91 and beyond (This plan covers 60 lifetime reserve days) These amounts may change for 2021.	Covered
Outpatient Surgery Services Including ambulatory surgical center services such as diagnostic colonoscopies	0%-20% of the cost	Covered
Primary Care Provider Visit	0%-20% of the cost	Covered
Specialist Visit	0%-20% of the cost	Covered
Virtual Visit Virtual visit for medical (including dermatology) and behavioral health through MDLIVE®[2]	$0	Not covered
Preventive Annual Medicare Wellness Visit	$0 in-network 0%-20% of the cost out-of-network	Covered

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/additional-benefits-snp** for more information.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.**	
Preventive Care*	$0 in-network 0%-20% of the cost out-of-network	Covered
Preventive Medicare-Covered Vaccines Such as flu, pneumonia, Hepatitis B	$0 in-network 0%-20% of the cost out-of-network	Covered
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	0%-20% of the cost, up to $90	Coverage may not be available outside the state of Wisconsin
International Emergency Coverage View the *Evidence of Coverage* at networkhealth.com/medicare/plan-materials for details	$90 per incident $100,000 Maximum benefit	Not covered
Urgent Care	0%-20% of the cost, up to $65	Covered
Diagnostic Tests Such as ultrasound, EKG, stress test	0%-20% of the cost	Covered
X-rays	0%-20% of the cost	Covered
Diagnostic Radiology Services Such as MRIs, CT scans	0%-20% of the cost	Covered
Diagnostic Lab Tests	0%-20% of the cost	Covered

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

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

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.**	
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues	0%-20% of the cost	Covered
Routine Hearing Exam	Not covered	Covered
Hearing Aids[2] Includes a three-year warranty with loss and damage insurance, up to six hearing aid follow up visits within three years and 16 batteries. Maximum of two hearing aids per year.	Select hearing aids discounted to $795-$2,370 per device (A savings of up to $1,050 per hearing aid.)	Not covered
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth	0%-20% of the cost	Covered
Comprehensive Dental Benefit[2]	$0 Cleaning (twice a year) $0 Dental X-ray(s) (bitewing 1 per year, full mouth 1 every 5 years) $0 Oral Exam (twice a year) $0 Basic Restorative Services 50% of the cost for major services (endodontics/ periodontics/extractions, prosthodontics, other oral/ maxillofacial surgery, other services) $3,000 Annual Maximum	Covered

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

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.**	
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye	0%-20% of the cost	Covered
Routine Eye Exam[2] One exam per year	$0 in-network, or $40 reimbursement out-of-network	Covered
Post-Cataract Eyewear[2] One pair of eyeglasses or contact lenses after each cataract surgery	0%-20% of the cost	Covered
Additional Eyewear[2]	$400 allowance in-network, or $400 reimbursement out-of-network	Covered
Outpatient Mental Health Individual or group therapy	0%-20% of the cost	Covered
Inpatient Mental Health[1] Per admission	Annual Medical Deductible $0-$1,408 In 2020 the amounts were: $0 per day, Days 1-60 $0-$352 per day, Days 61-90 $0-$704 per day, Days 91 and beyond (This plan covers 60 lifetime reserve days) These amounts may change for 2021.	
Skilled Nursing Facility[1] Per admission	In 2020 the amounts were: $0 per day, Days 1-20 $0-$176 per day, Days 21-100 A prior three-day inpatient hospital stay is required. These amounts may change for 2021.	Covered
Physical, Occupational, Speech Outpatient Therapy Includes comprehensive outpatient rehabilitation facility	0%-20% of the cost	Covered

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/additional-benefits-snp** for more information.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.**	
Ambulance - Air and Ground Services	0%-20% of the cost	Covered
Transportation - Non-Emergency Includes trips to medical and dental appointments, pharmacies, fitness centers, grocery stores, senior centers or local ADRC offices, health and wellness classes	24 one-way trips with no mileage limit, anywhere within the Network Health Medicare plan service area Additionally includes 24 one-way trips for all members diagnosed with ESRD to get to and from dialysis for treatment	Covered
Medicare Part B Drugs and Chemotherapy[1]	0%-20% of the cost	Covered
Medicare Part D Drugs See prescription drug chart for tier information	Covered	Covered
Radiation Therapy[1] Per service	0%-20% of the cost	Covered
Chiropractic Services Manipulation of the spine to correct misalignment of one or more of the bones of your spine	0%-20% of the cost	Covered
Diabetes Monitoring Supplies and Test Strips OneTouch™ and Accu-Chek™ test strips, continuous glucose monitoring supplies limited to FreeStyle Libre® and Dexcom®. All other brands are not covered.	0%-20% of the cost	Covered – One Touch Not covered – Accu-Chek Covered (prior authorization required) - Freestyle Libre and Dexcom continuous glucose monitors
Diabetic Shoe Inserts Copayment per pair	0%-20% of the cost	Covered
Dialysis Per treatment	0%-20% of the cost	Covered
Diabetes Management Tool	$0	Not Covered

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/additional-benefits-snp** for more information.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.	
Durable Medical Equipment[1] Such as insulin pumps, CPAP machines, prosthetic devices	0%-20% of the cost	Covered
Medicare-Covered Home Health Care Visits	$0	Covered
Opioid Treatment Services Counseling and therapy services provided by opioid treatment programs	0%-20% of the cost	Covered
Substance Abuse Services Outpatient individual or group therapy	0%-20% of the cost	Covered
Medicare-Covered Acupuncture	For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year 0%-20% of the cost	Covered
Acupuncture As an alternative to nausea medications, a maximum of 12 visits per year are covered for members who are undergoing chemotherapy	$0	Not covered
SilverSneakers® Fitness	Included	Not covered
Over-the-Counter Coverage[2] No rollover on quarterly allowance	$150 per quarter	Covered
Meal Delivery Following a hospital observation stay, a qualified inpatient hospital stay, a skilled nursing facility stay	28 meals	Not covered

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/additional-benefits-snp** for more information.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

2021 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 per visit for benefits that state 0%-20% of the cost.**	
Spark Wellness Program	Earn up to $100 in gift cards by completing your annual health risk assessment, annual wellness visit and flu shot.	Not covered
Bathroom Adaptation	With proper documentation, which includes a completed NetworkCares Bathroom Adaptation Reimbursement Form and attached itemized receipts and invoices detailing the cost of the bathroom adaptation services/items purchased, the plan will reimburse the paid amount or up to the maximum benefit of $300 each year for approved bathroom home adaptation services/items.	Not covered
Home-Based Palliative Care Consultation and Evaluation[1] One visit per year for all members diagnosed with end-stage (stage 4) cancer	$0	Not covered

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/additional-benefits-snp** for more information.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

PRESCRIPTION DRUG BENEFITS

Your Drug Costs	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In- and out-of-network: 0%-20% of the cost Other Part B drugs[1]: • In- and out-of-network: 0%-20% of the cost Part D Prescription Drug Deductible on Tier 1 $0, Tiers 2-5: $445	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs

2021 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE PREFERRED RETAIL COST-SHARING

After you reach your yearly deductible of $0-$445 for your Tier 2-5 drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

Tier	One-month supply For generic drugs (including brand drugs treated as generic), either:	Three-month supply For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $4 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $10 or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $8 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $20 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $42 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $90 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $225 or 15% of the cost
Tier 5 (Specialty)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

2021 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE STANDARD RETAIL COST-SHARING

After you reach your yearly deductible of $0-$445 for your Tier 2-5 drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

Tier	One-month supply For generic drugs (including brand drugs treated as generic), either:	Three-month supply For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $6 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $15; or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $14 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment; or lesser of $35 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $47 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $118 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $100 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $250 or 15% of the cost
Tier 5 (Specialty)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

2021 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE MAIL ORDER RETAIL COST-SHARING

After you reach your yearly deductible of $0-$445 for your Tier 2-5 drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

Tier	One-month supply For generic drugs (including brand drugs treated as generic), either:	Three-month supply For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment lesser of $4 or 15% of the cost	• $0 copayment for 31-90 day mail order
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment lesser of $8 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment lesser of $20 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $42 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $90 or 15% of the cost	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of $225 or 15% of the cost
Tier 5 (Specialty)	• $0 copayment; or • $1.30 copayment; or • $3.70 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.20 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

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

2021 NETWORK*CARES* SUMMARY OF BENEFITS

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay $0-$3.70 for drugs treated as generic and $0-$9.20 for drugs treated as brand.

PRE-ENROLLMENT CHECKLIST

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

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit **networkhealth.com/medicare/plan-materials** or call **855-653-4363** (TTY 800-947-3529) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2022.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

NOTES

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

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

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