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

Annual Notice of Changes for 2019

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

What to do now

1. ASK: Which changes apply to you

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

It's important to review your coverage now to make sure it will meet your needs next year.

Do the changes affect the services you use?

Look in Sections 1.1 and 1.5 for information about benefit and cost changes for our plan.

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

Will your drugs be covered?

Are your drugs in a different tier, with different cost sharing?

Do any of your drugs have new restrictions, such as needing approval from us before you fill your prescription?

Can you keep using the same pharmacies? Are there changes to the cost of using this pharmacy?

Review the 2019 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 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*Cares*, you don't need to do anything. You will stay in Network*Cares*.

If you want to **change to a different plan** that may better meet your needs, you can switch plans between now and December 31. Look in section 3.2, page 16 to learn more about your choices.

4. ENROLL: To change plans, join a plan between now and **December 31, 2018**

- If you **don't join another plan by December 31, 2018**, you will stay in Network*Cares*.
- If you **join another plan by December 31, 2018**, your new coverage will start on January 1, 2019.
- Starting in 2019, there are new limits on how often you can change plans. Look in section 4, page 17 to learn more.

Additional Resources

Please contact our customer service number at 855-653-4363 for additional information. (TTY users should call 800-947-3529.) Hours are Monday through Friday, 8 a.m. to 8 p.m. From October 1, 2018 through March 31, 2019 we are available every day; from 8 a.m. to 8 p.m.

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; please contact customer service if you need plan information in another format.

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*Cares*

Network Health Medicare Advantage plans include PPO, MSA and HMO plans. 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.

When this booklet says "we," "us," or "our," it means *Network Health Insurance Corporation*. When it says "plan" or "our plan," it means Networ*kCares*.

Summary of Important Costs for 2019

The table below compares the 2018 costs and 2019 costs for Network*Cares* in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

Cost	2018 (this year)	2019 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Deductible	In 2017, the annual Part B deductible was $0 or $183. These amounts may change for 2018. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	In 2018, the annual Part B deductible was $0 or $183. These amounts may change for 2019. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.
Doctor office visits	Primary care visits: 0% - 20% per visit Specialist visits: 0% - 20% per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit	Primary care visits: 0% - 20% per visit Specialist visits: 0% - 20% per visit If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0 per visit.

Cost	2018 (this year)	2019 (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** In 2017, the amounts for each benefit period were $0 or: • Days 1-60: $1316 deductible + • Days 61-90: $329 per day+ • Days 91-150: $658 per lifetime reserve day+ **Out-of-Network** In 2017, the amounts for each benefit period were $0 or: • Days 1-60: $1316 deductible+ • Days 61-90 $329 per day+ • Days 91-150: $658 per lifetime reserve day+ +These amounts may change for 2018. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.	**In-Network** In 2018, the amounts for each benefit period were $0 or: • Days 1-60: $1340 deductible + • Days 61-90: $335 per day+ • Days 91-150: $670 per lifetime reserve day+ **Out-of-Network** In 2018, the amounts for each benefit period were $0 or: • Days 1-60: $1340 deductible+ • Days 61-90 $335 per day+ • Days 91-150: $670 per lifetime reserve das+ +These amounts may change for 2019. If you are eligible for Medicare cost-sharing assistance under Medicaid, you pay $0.

Cost	2018 (this year)	2019 (next year)
Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $335 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0, $1, $1.25, $3.35, or 15% at a preferred pharmacy and $0, $1.25, $3, $3.35, or 15% at a standard pharmacy. • Drug Tier 2: $0, $1.25, $3.35, $8 or 15% at a preferred pharmacy and $0, $1.25, $3.35, $14 or 15% at a standard pharmacy. • Drug Tier 3: $0, $1.25, $3.35, $3.70, $8.35, $42 or 15% at a preferred pharmacy and $0, $1.25, $3.35, $3.70, $8.35, $47 or 15% at a standard pharmacy. • Drug Tier 4: $0, $1.25, $3.35, $3.70, $8.35, $84 or 15% at a preferred pharmacy and $0, $1.25, $3.35, $3.70, $8.35, $91 or 15% at a standard pharmacy. • Drug Tier 5: $0, $1.25, $3.35, $3.70, $8.35, 15% or 26% at both preferred and standard pharmacies.	Deductible: $400 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0, $1.25, $3.40, $4, or 15% at a preferred pharmacy and $0, $1.25, $3.40, $6 or 15% at a standard pharmacy. • Drug Tier 2: $0, $1.25, $3.40, $8 or 15% at a preferred pharmacy and $0, $1.25, $3.40, $14 or 15% at a standard pharmacy. • Drug Tier 3: $0, $1.25, $3.40, $3.80, $8.50, $42 or 15% at a preferred pharmacy and $0, $1.25, $3.40, $3.80, $8.50, $47 or 15% at a standard pharmacy. • Drug Tier 4: $0, $1.25, $3.40, $3.80, $8.50, $84 or 15% at a preferred pharmacy and $0, $1.25, $3.40, $3.80, $8.50, $91 or 15% at a standard pharmacy. • Drug Tier 5: $0, $1.25, $3.40, $3.80, $8.50, 15% or 25% at both preferred and standard pharmacies.

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From in-Network providers: $6700 From in-network and out-of-network providers combined: $10,000 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From in-Network providers: $6700 From in-network and out-of-network providers combined: $10,000 If you are eligible for Medicare cost-sharing assistance under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

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SECTION 1 Changes to Medicare Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2018 (this year)	2019 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	No change

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

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

Cost	2018 (this year)	2019 (next year)
Maximum out-of-pocket amount **Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.** If you are eligible for Medicaid assistance with Part A and Part B copays and deductibles, you are **not** responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount.	$6700 Once you have paid $6700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	No change

Cost	2018 (this year)	2019 (next year)
Combined in and out-of-network maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. Your costs for covered medical services (such as copays and deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$10,000 Once you have paid $10,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.	No change

Section 1.3 – Changes to the Provider Network

There are changes to our network of providers for next year. An updated Provider Directory is located on our website at networkhealth.com. You may also call customer service for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2019 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, Medicare requires that we 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 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 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. You may also call customer service for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2019 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

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

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, *Benefits Chart (what is covered and what you pay)*, in your *2019 Evidence of Coverage.* A copy of the *Evidence of Coverage* was included in this envelope.

Cost	2018 (this year)	2019 (next year)
Emergency Care	**In-Network** **0% - 20%** of the cost (up to $80) for Medicare covered emergency room visits. **Out-of-Network** **0% - 20%** of the cost (up to $80) for Medicare covered emergency room visits.	**In-Network** **0% - 20%** of the cost (up to $90) for Medicare covered emergency room visits. **Out-of-Network** **0% - 20%** of the cost (up to $90) for Medicare covered emergency room visits.

Cost	2018 (this year)	2019 (next year)
Hearing Aids	As a supplemental benefit, you have access to the following hearing aids at the prices listed below when you see a participating provider: • Cros Pure Signia and Cros Widex: $1000 each hearing aid • 2nd Generation Midlevel: $1220 each hearing aid • 2nd Generation High Level: $1420 each hearing aid • 2nd Generation Premium: $1620 each hearing aid • 1st Generation Midlevel: $1565 each hearing aid • 1st Generation High Level: $1765 each hearing aid • 1st Generation Premium: $1985 each hearing aid Hearing aids are available from four (4) manufacturers: Widex, Siemens, Oticon and Starkey.	As a supplemental benefit, you have access to the following hearing aids at the prices listed below when you see a participating provider: • 2nd Generation Midlevel: $1220 each hearing aid • 2nd Generation High Level: $1420 each hearing aid • 2nd Generation Premium: $1620 each hearing aid • 1st Generation Midlevel: $1565 each hearing aid • 1st Generation High Level: $1765 each hearing aid • 1st Generation Premium: $1985 each hearing aid Hearing aids are available from four (4) manufacturers: Widex, Siemens, Oticon and Starkey.
Health and wellness education programs	Up to a maximum reimbursement of $50 every year of approved health and wellness classes.	Not covered

Cost	2018 (this year)	2019 (next year)
Vision care	**In-Network** **0%** of the cost for non-Medicare covered refraction eye exams. Reimbursement of up to a maximum of $510 toward non-Medicare covered eyewear (1 pair of eyeglasses (lenses and frames) or 12 pairs of contact lenses) annually. An updated prescription is required. **Out-of-Network** **0%** of the cost for non-Medicare covered refraction eye exams. Reimbursement of up to a maximum of $510 toward non-Medicare covered eyewear (1 pair of eyeglasses (lenses and frames) or 12 pairs of contact lenses) annually. An updated prescription is required.	**In-Network** **0%** of the cost for non-Medicare covered refraction eye exams. Reimbursement of up to a maximum of $500 toward non-Medicare covered eyewear annually, with a valid prescription. **Out-of-Network** **0%** of the cost for non-Medicare covered refraction eye exams. Reimbursement of up to a maximum of $400 toward non-Medicare covered eyewear annually, with a valid prescription.

Cost	2018 (this year)	2019 (next year)
Dental Services	$2500 Annual Maximum Benefit. Fluoride treatments are covered once (1) a year. Bitewing x-rays are covered once (1) a year. **In-Network or Out-of-Network** 0% of the cost for non-Medicare covered preventive dental services. 10% of the cost for non-Medicare covered emergency palliative treatment, minor restorative services (fillings), and simple extractions. 50% of the cost for non-Medicare covered endodontics, periodontics, surgical extractions, major restorative services (crowns), prosthodontics, relines and repairs to bridges and dentures, and oral surgery.	$3000 Annual Maximum Benefit. Fluoride treatments are covered once (1) a year. Bitewing x-rays are covered once (1) a year. **In-Network or Out-of-Network** 0% of the cost for non-Medicare covered preventive dental services. 0% of the cost for non-Medicare covered emergency palliative treatment, minor restorative services (fillings), and simple extractions. 50% of the cost for non-Medicare covered endodontics, periodontics, surgical extractions, major restorative services (crowns), prosthodontics, relines and repairs to bridges and dentures, and oral surgery.

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).

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 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. For 2019, members in long term care (LTC) facilities will now receive a temporary supply that is the same amount of temporary days supply provided in all other cases: a 31-day supply of medication rather than the amount provided in 2018 a 90-day supply of medication. (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.

Starting in 2019, we may immediately remove a brand name drug on our Drug List if, at the same time, we replace it with a new generic drug on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. This means if you are taking the brand name drug that is being replaced by the new generic (or the tier or restriction on the brand name drug changes), you will no longer always get notice of the change 60 days before we make it or get a 60-day refill of your brand name drug at a network pharmacy. If you are taking the brand name drug, you will still get information on the specific change we made, but it may arrive after the change is made.

Also, starting in 2019, before we make other changes during the year to our Drug List that require us to provide you with advance notice if you are taking a drug, we will provide you with notice 30, rather than 60, days before we make the change. Or we will give you a 30-day, rather than a 60-day, refill of your brand name drug at a network pharmacy.

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

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug costs. If you receive "Extra Help" and haven't received this insert by September 30, 2018 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 in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the enclosed *Evidence of Coverage*.)

Changes to the Deductible Stage

Stage	2018 (this year)	2019 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your: Part D drugs until you have reached the yearly deductible.	The deductible is $335.	The deductible is $400.

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	2018 (this year)	2019 (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 a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3 or $3.35 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1, $1.25 or $3.35 per prescription or 15% of the total cost. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3.35 or $14 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.35 or $8 per prescription or 15% of the total cost. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3.35, $3.70, $8.35 or $47 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.35, $3.70, $8.35 or $42 per prescription or 15% of the total cost. **Tier 4 Non-Preferred Brand Drugs:** *Standard cost-sharing:* You pay $0, $1.25, $3.35, $3.70, $8.35 or $91 per prescription or 15% of the total cost. *Preferred cost-sharing:* You pay $0, $1.25, $3.35, $3.70, $8.35 or $84 per prescription or 15% of the total cost.	Your cost for a one-month supply at a network pharmacy: **Tier 1 Preferred Generic Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3.40 or $6 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.40 or $4 per prescription or 15% of the total cost. **Tier 2 Generic Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3.40 or $14 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.40 or $8 per prescription or 15% of the total cost. **Tier 3 Preferred Brand Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3.40, $3.80, $8.50 or $47 per prescription or 15% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.40, $3.80, $8.50 or $42 per prescription or 15% of the total cost. **Tier 4 Non-Preferred Brand Drugs:** *Standard cost-sharing:* You pay $0, $1.25, $3.40, $3.80, $8.50 or $91 per prescription or 15% of the total cost. *Preferred cost-sharing:* You pay $0, $1.25, $3.40, $3.80, $8.50 or $84 per prescription or 15% of the total cost.

Stage	2018 (this year)	2019 (next year)
	Tier 5 Specialty Drugs: *Standard cost sharing:* You pay $0, $1.25, $3.35, $3.70 or $8.35 per prescription or 15% or 26% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.35, $3.70 or $8.35 per prescription or 15% or 26% of the total cost. Once your total drug costs have reached $3,750, you will move to the next stage (the Coverage Gap Stage).	**Tier 5 Specialty Drugs:** *Standard cost sharing:* You pay $0, $1.25, $3.40, $3.80 or $8.50 per prescription or 15% or 25% of the total cost. *Preferred cost sharing:* You pay $0, $1.25, $3.40, $3.80 or $8.50 per prescription or 15% or 25% of the total cost. Once your total drug costs have reached $3,820, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

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

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

SECTION 2 Administrative Changes

Cost	2018 (this year)	2019 (next year)
Mail order copayment for Tier 1 drugs on the Drug List greater than a 30-day supply during the deductible and initial coverage phase.	$5 copay	*$0 copay*

SECTION 3 Deciding Which Plan to Choose

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

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare, you will automatically stay enrolled as a member of our plan for 2019.

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 2019 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.

Your new coverage will begin on the first day of the following month. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2019*, call your State Health Insurance Assistance Program (see Section 6), 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*Cares*.

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

To change to Original Medicare without a prescription drug plan, you must either:

- Send us a written request to disenroll. Contact customer service if you need more information on how to do this (phone numbers are in Section 8.1 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.

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

SECTION 4 Changing Plans

If you want to change to a different plan or Original Medicare for next year, you can do it from now until December 31. The change will take effect on January 1, 2019.

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. Starting in 2019, there are new limits on how often you can change plans. For more information, see Chapter 10, Section 2.1 of the *Evidence of Coverage.*

Note: Effective January 1, 2019, if you're in a drug management program, you may not be able to change plans.

If you enrolled in a Medicare Advantage plan for January 1, 2019, 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, 2019. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

SECTION 5 Programs That Offer Free Counseling about Medicare and Medicaid

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

For questions about your Wisconsin Medicaid benefits, contact Wisconsin Medicaid at 800-362-3002, Monday through Friday, 7:00 a.m. to 6:00 p.m. TTY users should call 888-701-1251. Ask how joining another plan or returning to Original Medicare affects how you get your Wisconsin Medicaid coverage.

SECTION 6 Programs That Help Pay for Prescription Drugs

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

"Extra Help" from Medicare. Because you have Medicaid, you are already enrolled in 'Extra Help,' also called the Low Income Subsidy. Extra Help pays some of your prescription drug premiums, annual deductibles and coinsurance. Because you qualify, you do not have a coverage gap or late enrollment penalty. If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/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 Network*Cares*

Questions? We're here to help. Please call customer service at 855-653-4363. (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 2019 *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 2019. For details, look in the 2019 *Evidence of Coverage* for Network*Cares.* The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

Visit our Website

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

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

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

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 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 2019*

You can read *Medicare & You 2019* 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.

Section 7.3 – Getting Help from Medicaid

To get information from Medicaid you can call Wisconsin Medicaid at 800-362-3002. TTY users should call 888-701-1251.