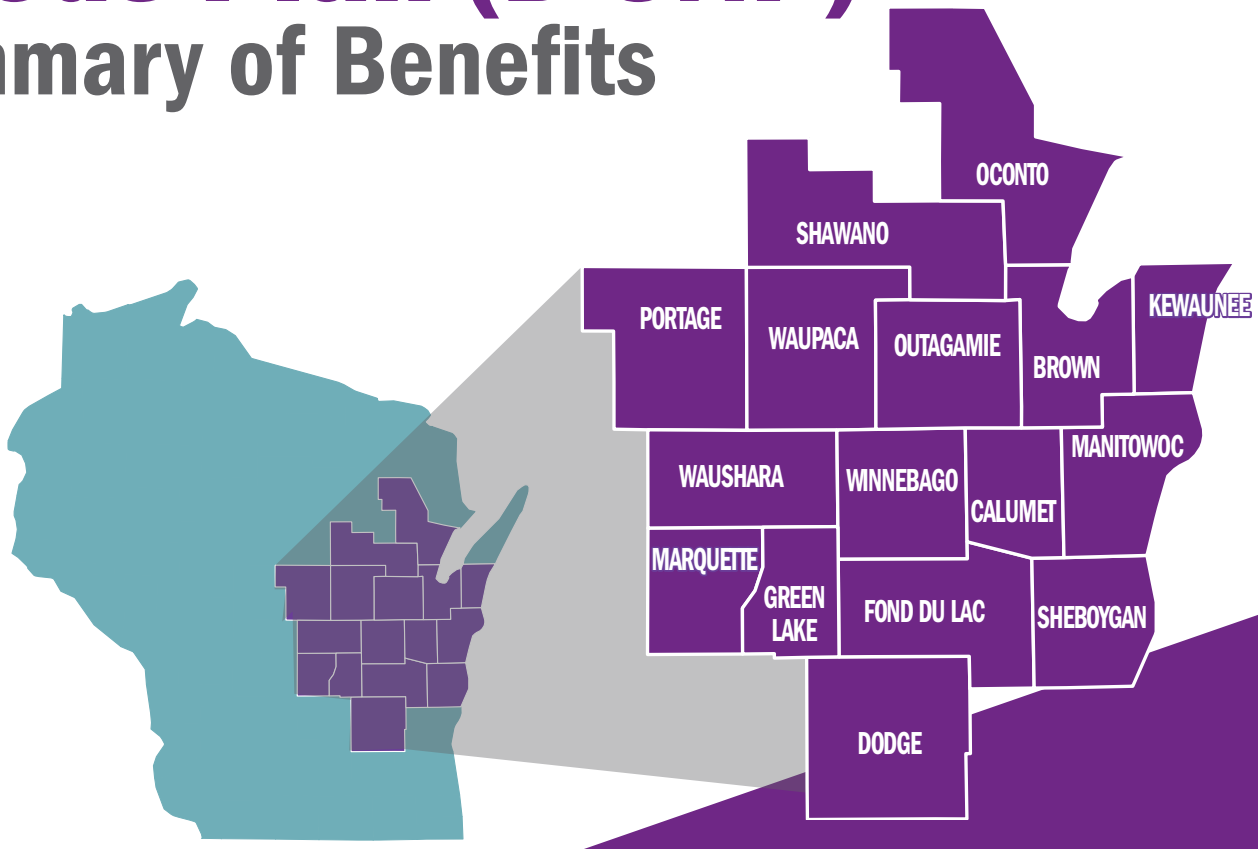
network health

2022

NetworkCares PPO Dual-Eligible Special Needs Plan (D-SNP)

Summary of Benefits

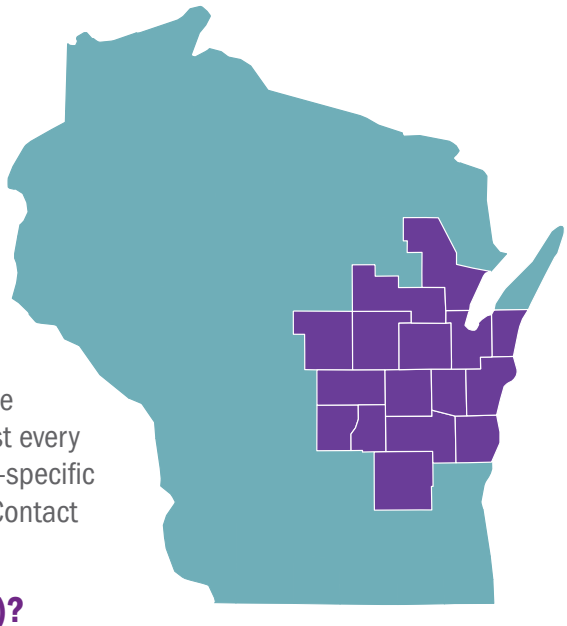


■ NetworkCares Service Area Counties

2022 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 the 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.

2022 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS (unless specified) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 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 2021 the amounts were: $0-$203 depending on your level of Medicaid eligibility. These amounts may change for 2022.	
Annual Maximum Out-of-Pocket– (Does not include Part D prescription drugs)	$6,700 for services you receive from in-network providers $10,000 for services you receive from any provider, your costs for services received from in-network providers will count toward this limit	
Common Services		
Primary Care Provider Visit	0%-20% of the cost	Covered
Specialist Visit	0%-20% of the cost	Covered
Preventive Care*	$0 in-network 0%-20% of the cost out-of-network	Covered
Annual Medicare Wellness Visit	$0 in-network 0%-20% of the cost out-of-network	Covered
Medicare-Covered Vaccines– Flu, pneumonia, COVID-19	$0 in-network 0% of the cost out-of-network	Covered
Part B Vaccines– Hepatitis B, all other Part B	$0 in-network 0%-20% of the cost out-of-network	Covered
Inpatient Hospital Services[1]– Per admission	Annual Medical Deductible $0-$1,484 In 2021 the amounts were: $0 per day, Days 1-60 $0-$371 per day, Days 61-90 $0-$742 per day, Days 91 and beyond (This plan covers 60 lifetime reserve days) These amounts may change for 2022.	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**

[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.

2022 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS (unless specified) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Outpatient Hospital Services– Including ambulatory surgical center services such as diagnostic colonoscopies	0%-20% of the cost	Covered
Labs	0%-20% of the cost	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– Advanced Imaging	0%-20% of the cost	Covered
Urgent Care Visit	0%-20% of the cost, up to $65	Covered
Emergency Room Visit	0%-20% of the cost, up to $90	Coverage may not be available outside the state of Wisconsin
Air and Ground Ambulance Services	0%-20% of the cost	Covered
Durable Medical Equipment– Such as insulin pumps[1], CPAP machines, prosthetic devices[1]	0%-20% of the cost	Covered
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit	Covered
MDLIVE®Virtual Visit[2]– Virtual visit for medical (including dermatology) and mental health	$0	Not covered
Medicare Part B Drugs	0%-20% of the cost	Covered
Travel Coverage		
Travel within the United States	Receive in-network coverage when you see a provider outside Wisconsin, anywhere in the United States	Coverage may not be available outside the state of Wisconsin
International Emergency Coverage– View the Evidence of Coverage for details at networkhealth. com/ medicare/plan-materials	$90 per incident $100,000 Maximum benefit	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.

2022 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS (unless specified) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.**	
Additional Benefits		
Preventive and Comprehensive Dental Coverage[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
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
Annual Routine Vision Exam[2]	$0 in-network, or $40 reimbursement out-of-network	Covered
Diagnostic Eye Exam– To diagnose and treat diseases and conditions of the eye	0%-20% of the cost	Covered
Additional Eyewear[2]	$400 allowance in-network, or $400 reimbursement out-of-network	Covered
Post-Cataract Eyewear– One pair of eyeglasses or contact lenses after each cataract surgery	0%-20% of the cost	Not covered
Over-the-Counter Coverage[2]	$155 per quarter	Covered
Fitness with SilverSneakers®[2]	Included	Not covered
Annual Routine Hearing Exam[2]	$0 in-network, or $40 out-of-network	Covered
Diagnostic Hearing Exam– Exam to diagnose and treat hearing issues	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.

2022 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS (unless specified) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Hearing Aids[2]– Maximum of two hearing aids per year Hearing aid evaluation and fitting included	$679-$2,299 per device	Not covered
Non-Emergency Transportation[2]	24 one-way trips, anywhere within the Network Health Medicare Advantage Plan service area Additionally includes 24 one-way trips for members with ESRD to get to and from dialysis	Covered
Meal Delivery[2]– Following a hospital observation stay, qualified inpatient hospital stay, skilled nursing facility stay	28 meals	Not covered
Wellness Rewards[2]	Earn up to $100 in gift cards by completing your annual health risk assessment, annual wellness visit and flu shot.	Not covered
Bathroom Adaptation[2]	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
Mental Health/Substance Abuse		
Outpatient Mental Health– Individual or group therapy	0%-20% of the cost	Covered
Inpatient Mental Health[1]– Per admission	Annual Medical Deductible $0-$1,484 In 2021 the amounts were: $0 per day, Days 1-60 $0-$371 per day, Days 61-90 $0-$742 per day, Days 91 and beyond (This plan covers 60 lifetime reserve days) These amounts may change for 2022.	Covered
Opioid Treatment Services	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.

2022 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS (unless specified) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Substance Abuse Services– Outpatient individual or group therapy	0%-20% of the cost	Covered
Recovery and Rehabilitation Services		
Skilled Nursing Facility[1]– Per admission	In 2021 the amounts were: $0 per day, Days 1-20 $0-$185.50 per day, Days 21-100 A prior three-day inpatient hospital stay is required. These amounts may change for 2022.	Covered
Outpatient Physical[1], Occupational[1], Speech Therapy	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
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
Medicare-Covered Home Health Care Visits[1]	$0	Covered
Services for Specific Conditions		
Cancer		
Chemotherapy[1]	0%-20% of the cost	Covered
Radiation Therapy[1]– Per service	0%-20% of the cost	Covered
Acupuncture– Up to 12 visits per year are covered for members who are undergoing chemotherapy and experiencing nausea	$0	Not covered
Home-Based Palliative Care[1]– One palliative care evaluation and two follow up visits	$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.

2022 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (Includes pharmacy) (PPO D-SNP)	Medicaid
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS (unless specified) If you are eligible for Medicare cost sharing assistance under Medicaid,	
Diabetes		
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	Continuous glucous monitoring supplies requires prior authorization from Medicaid OneTouch test strips covered Accu-Chek test strips not covered
Diabetic Shoes and Inserts– Copayment per pair	0%-20% of the cost	Covered
Diabetes Management Tool	$0	Not covered
End-Stage Renal Disease		
Dialysis– Per treatment	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.

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: $480	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs

2022 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE PREFERRED RETAIL PHARMACY COST-SHARING

After you reach your yearly deductible of $0-$480 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 • $1.35 copayment; or • $3.95 copayment; or lesser of $5 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $12 or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $10 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $25 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $42 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $95 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $237 or 15% of the cost
Tier 5 (Specialty)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or 15% of the cost	Not offered

2022 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE STANDARD RETAIL OR MAIL ORDER PHARMACY COST-SHARING

After you reach your yearly deductible of $0-$480 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 • $1.35 copayment; or • $3.95 copayment; or lesser of $8 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $20 or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $17 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $42 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $47 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $117 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $100 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $250 or 15% of the cost
Tier 5 (Specialty)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or 15% of the cost	Not offered

Your Drug Costs

INITIAL COVERAGE PREFERRED MAIL ORDER PHARMACY COST-SHARING

After you reach your yearly deductible of $0-$480 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 • $1.35 copayment; or • $3.95 copayment; or lesser of $5 or 15% of the cost	• $0 copayment for 31-90 day mail order
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment; or lesser of $10 or 15% of the cost	• $0 copayment for 31-90 day mail order
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $42 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $95 or 15% of the cost	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or lesser of $237 or 15% of the cost
Tier 5 (Specialty)	• $0 copayment; or • $1.35 copayment; or • $3.95 copayment For all other drugs, either: • $0 copayment; or • $4.00 copayment; or • $9.85 copayment; or 15% 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 because you may pay more than you pay at an in-network pharmacy.

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 medicine 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, 2023.
- ☐ 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.

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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 member experience 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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