2023 Summary of Benefits

(HMO D-SNP) | H7598

Cooperative ADVANTAGE

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 customer service representative at (888) 203-7770 (TTY users call (800)-947-3529).

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 group-health.com/cooperative-advantage or call (888) 203-7770 (TTY users call (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/co-insurance may change on January 1, 2024
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid. D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies).

This is a summary of health and prescription drug services covered by Cooperative Advantage (HMO D-SNP) January 1, 2023 - December 31, 2023.

Cooperative Advantage (HMO D-SNP) is a Medicare Advantage Health Maintenance

Organization (HMO) Plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

2023 | SUMMARY OF BENEFITS

The benefit information provided is a summary of what the plan covers and what you pay. It does not list every service that we cover or list every limitation or exclusion. This information is not a complete description of benefits. The complete list of services we cover is found in the Evidence of Coverage. You can review the Evidence of Coverage at group-health.com/cooperative-advantage. If you would like a printed copy of the Evidence of Coverage mailed to you, please call our Member Services Department at 1-888-203-7770, TTY users can call 1-800-947-3529.

CONTACT US AT:

- ➔ Toll free 1-888-203-7770, TTY users can call 1-800-947-3529.
- ➔ Hours of operation from April 1 – September 30 are Monday through Friday, 8:00 A.M. to 8:00 P.M. From October 1 – March 31, hours of operation are 8:00 A.M. to 8:00 P.M., seven days a week.

TO ENROLL IN COOPERATIVE ADVANTAGE (HMO D-SNP) YOU:

- ➔ Are entitled to Medicare Part A.
- ➔ Enrolled in Medicare Part B.
- ➔ Reside in the service area of Cooperative Advantage.
- ➔ Are a U.S. citizen or lawfully present in the United States.
- ➔ Eligible and enrolled in Wisconsin Medicaid.

Cooperative Advantage's network of doctors, hospitals, other providers, and pharmacies can be found in the provider or pharmacy directory on our website at group-health.com/cooperative-advantage. You can also call Member Services at 1-888-203-7770, TTY users can call 1-800-947-3529 to request a copy to be mailed to you.

SERVICE AREA

- Adams
- Ashland
- Barron
- Bayfield
- Buffalo
- Burnett
- Chippewa
- Clark
- Columbia
- Crawford
- Douglas
- Dunn
- Eau Claire
- Forest
- Grant
- Green
- Iowa
- Iron
- Jackson
- Juneau
- La Crosse
- Lafayette
- Langlade
- Lincoln
- Marathon
- Monroe
- Oneida
- Pepin
- Pierce
- Polk
- Portage
- Price
- Richland
- Rusk
- Sauk
- Sawyer
- Shawano
- St. Croix
- Taylor
- Trempealeau
- Vernon
- Vilas
- Washburn
- Wood

If you use a non-network provider, we may not pay for these services.

Out-of-network/non-contracted providers are under no obligation to treat Cooperative Advantage's members, except in emergency situations. Please call our Member Services at 1-888-203-7770, TTY users can call 1-800-947-3529 or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Benefits, premium, deductible and/or copayments/coinsurance many change at any time. You will receive notice when necessary.

To know more about your coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

This information is not a complete description of benefits. Call Member Services at 1-888-203-7770, TTY users can call 1-800-947-3529 for more information.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

You must continue to pay your Medicare Part B premium.

Services that require prior authorization are noted with an asterisk symbol.

BENEFIT DESCRIPTION	**Cooperative Advantage** (HMO D-SNP)
Monthly Plan Premium and Deductible	$0 – $43.10 (If you get Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.)
Premium – Part B If you pay a Medicare Part B Premium, you must continue to do so.	$164.90
Maximum Out-of-Pocket Responsibility	$8,300
*Inpatient Hospital Coverage	You pay the 2023 Original Medicare cost-sharing amounts. · $1,600 deductible and no coinsurance for days 1-60 · Coinsurance of $400 per day for days 61-90 · There is a coinsurance after 90 days · Prior Authorization Required
Outpatient Hospital Coverage · Outpatient Blood Services · Observation · Hospital outpatient surgeries	20% Coinsurance · Prior Authorization Required
*Ambulatory Surgery Center	20% Coinsurance · Prior Authorization Required
Doctor Visits: · Primary Care Providers · Specialists	 · 20% Coinsurance · 20% Coinsurance
Preventive Care	No cost-share
Emergency Care	20% Coinsurance, maximum $95 per visit
Urgently Needed Services	20% coinsurance, maximum $60 per visit
*Outpatient Diagnostic Services/ Labs/Imaging · Diagnostic tests and procedures · Labs · Diagnostic radiology · X-rays	20% Coinsurance · Prior Authorization Required for genetic testing and CT, MRI, and PET scans.

Hearing Services · Routine Hearing Exam · Medicare Hearing Exam · Hearing Aids	· 1 hearing exam per year · 20% Coinsurance · 1 set of hearing aids every year

Dental Services · Oral Exam, cleaning, x-rays	Not Covered
Vision Services	Not Covered
*Mental Health Services · Outpatient Mental Health Services	· 20% Coinsurance · Prior Authorization Required for psychological and neuropsychological testing, day treatment, and intensive outpatient services.
Skilled Nursing Facility · Requires member to need daily skilled nursing and/ or skilled rehabilitation services. Prior Authorization is required.	You pay the 2023 Original Medicare cost-sharing amounts. · You pay nothing for the first 20 days of each benefit period. · You pay $200 per day for days 21-100. · You pay all costs for each day after day 100.
*Physical, Occupational, and Speech Therapy	· 20% Coinsurance · Prior Authorization Required
*Ambulance · Non-emergent	· 20% Coinsurance · Prior Authorization Required
Transportation	Not Covered
*Medicare Part B Drugs**	· 20% Coinsurance · Prior Authorization Required
Retail Pharmacy**	30, 60, 90 day supplies
Durable Medical Equipment · *Prosthetics/Medical Supplies · *Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	· 20% Coinsurance · * Prior Authorization Required

* Prior Authorization

** Costs may differ based on pharmacy type or status (e.g, preferred/non-preferred, mail order, long-term care (LTC) or home infusion, and 30 or 90 day supply.)

PART D PRESCRIPTION DRUGS

Below is the cost-sharing you will pay in deductible, initial coverage and coverage gap phases for Part D prescription drugs. In the catastrophic coverage phase you pay a small coinsurance percentage or copayment for covered drugs for the rest of the year. We cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. If the cost of your drug is less than the listed copay, you will pay only the lower amount.

All part D vaccines including but not limited to the shingles vaccine, tetanus vaccine and tetanus-diphtheria-pertussis (Tdap) vaccine given as routine vaccinations, are covered for members with Part D coverage. Our plan groups each medication into one “tier.”

The amount you pay depends on what stage of the benefit you have reached. Cost-sharing may change when entering another phase of the Part D benefit or if you qualify for “Extra Help.” To find out if you qualify for “Extra Help,” please contact the Social Security Office at 1-800-772-1213 Monday – Friday, 7 AM – 7 PM. TTY users should call 1-800-325-0778.

COOPERATIVE ADVANTAGE (HMO D-SNP)

Tier	Standard Retail		
	30 day	60 day	90 day
Tier 1 Covered Drugs	25%	25%	25%

EXTRA HELP

This table shows what your co-pay would be per prescription if you get Extra Help.

Low Income Subside (LIS) Level	Your cost sharing amount for generic/brand drugs treated like generics	Your cost-sharing amount for all other drugs
LIS 1	$0	$0
LIS 2	$1.45 (each prescription)	$4.30 (each prescription)
LIS 3	$4.15 (each prescription)	$10.35 (each prescription)
LIS 4	15% (each prescription)	15% (each prescription

Medicaid Benefit Comparison

In order to be eligible to enroll in Cooperative Advantage, you must also be eligible for full Wisconsin Medicaid benefits. Because you will have Medicare and Medicaid coverage, your services will be paid by Medicare first, and then by your Wisconsin Medicaid Plan. Full Medicaid benefits include payment of some or all of your Medicare cost-sharing such as, premiums, deductibles, coinsurance, and copays. Medicaid covered services may be provided by Cooperative Advantage, a different HMO that has a contract with Wisconsin Medicaid, or through fee-for-service. This covered services information is provided as general information. Coverage information may vary based on your Medicaid category.

In order to remain eligible for Cooperative Advantage, you must maintain your Medicaid eligibility. If you no longer qualify for Medicaid, you will have a grace period in Cooperative Advantage before you are involuntarily disenrolled. The amount you pay for Medicare cost-sharing during this period may change.

If you have any questions related to a particular service or category, please call our Member Services Department at 1-888-203- 7770, TTY users can call 1-800-947-3529.

Benefit	Cooperative Advantage Medicare	Medicaid
Outpatient Care		
Acupuncture	Not Covered	Not Covered
Ambulance Services (Must be medically necessary)	Covered 20% coinsurance	Covered emergency and non-emergency transportation to and from a certified provider for a covered service $2 copay for non-emergency ambulance trips $1 copay per trip for transportation by specialized medical vehicle No copay for transportation by common carrier or emergency ambulance Not Covered: Non-emergent medical, includes ambulance and specialized vehicle

Ambulatory Surgical Services	Covered 20% coinsurance	Coverage of certain surgical procedures and related lab services $3 copay per service
Cardiac and Pulmonary Rehabilitation Services	Covered 20% coinsurance	Covered
Chiropractic Services	Covered	Covered $0.50-$3 copay per service
Dental Services	Not Covered	Covered $0.50-$3 copay per service
Diabetes Programs and Supplies	Covered 20% coinsurance	Covered $0.50 per prescription for diabetic supplies and $0.50 to $3 copay per service for other services
Diagnostic Tests, X-rays, Lab Services, and Radiology Services	Covered 20% coinsurance for diagnostic procedures/tests 0% coinsurance for lab services	Covered (including laboratory and radiology)
Dialysis Services	Covered 20% coinsurance	Covered
Durable Medical Equipment	Covered 20% coinsurance	Covered $0.50 to $3 copay per item. Rental items are not subject to copay
Emergency Care	Covered 20% coinsurance $95 max per visit	Covered
Hearing Services	Covered 20% coinsurance No copay for hearing aids	Covered $0.50 to $3 copay per service No copay for hearing aid batteries
Home Health Services	Covered: Skilled nursing, Physical, Occupational, and Speech Therapy Not covered: Personal care worker and private duty nursing	Covered: Skilled nursing, OT, PT, ST, personal care worker, and private duty nursing
Outpatient Mental Health Care **This includes psychosocial rehabilitative services,**	Covered 20% coinsurance Not covered: Residential Treatment	Covered Not including room and board $0.50 to $3 copay per service, limited to the

including case management services, provided by staff of a certified community support program		first 15 hours or $825 of services, whichever comes first, provided per calendar year. Copays are not required when services are provided in a hospital setting or for residential substance use disorder treatment services
Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	Covered 20% coinsurance	Covered $0.50 to $3 copay per service. Copay obligation limited to the first 30 hours to $1,500, whichever occurs first, during one calendar year (copay limited calculated separately for each discipline)
Outpatient Hospital Services	Covered 20% coinsurance	Covered $3 copay per visit
Outpatient Substance Abuse Care	Covered 20% coinsurance Not Covered: Residential Treatment	Covered, includes residential treatment Not including room and board $0.50 to $3 copay per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. Copays are not required when services are provided in a hospital setting or for residential
Over-the-Counter Items	Not covered	Some over the counter drugs are covered. $0.50 copay
Podiatry Services	Covered	Covered $0.50 to $3 copay per service, limited to $30 per provider per calendar year
Physician Specialist Services	Covered 20% coinsurance	Covered, including laboratory and radiology management $0.50 to $3 copay per service; limited to $30 per provider per calendar year. No copay for emergency services,

		preventative services, anesthesia, or clozapine management.
Primary Care Physician Services	Covered	Covered, including laboratory and radiology management. $0.50 to $3 copay per service; limited to $30 per provider per calendar year. No copay for emergency services, preventative services, anesthesia, or clozapine management.
Psychiatric Services	Covered	Covered $0.50 to $3 copay per service, limited to the first 15 hours or $825 of services, whichever comes first, provided per calendar year. Copays are not required when services are provided in a hospital setting or for residential substance use disorder treatment services
Transportation Services (Routine)	Not Covered	Covered $2 copay for non-emergency ambulance trips $1 copay per trip for transportation by specialized medical vehicle No copay for transportation by common carrier or emergency ambulance.
Worldwide Emergency/Urgent Coverage (out of service area)	Not covered	Not Covered
Urgently Needed Services	Covered 20% coinsurance	Covered
Vision Services	Not Covered	Covered $0.50 to $3 copay per service. No copay for eyeglasses selected from the Medicaid collection
Inpatient Care		

Inpatient Hospital Care (includes substance abuse and rehabilitative services)	Covered	Covered
Inpatient Mental Health Services	Covered	Covered
Skilled Nursing Facility	Covered	Covered
Hospice		
Hospice Services	Covered by Original Medicare	Covered
Other Services		
Kidney Disease Education	Covered 20% coinsurance	Covered
Prescription Drug Benefits		
Outpatient Prescription Drugs	Covered	Covered Coverage of generic and brand name prescription drugs and some over the counter (OTC) drugs. $0.50 for over-the-counter drugs $1 for generic drugs $3 for brand name drugs Copayments are limited to $12 per member, per provider, per month. Over-the-counter drugs do not count toward the $12 maximum.
Additional Medicaid Benefits For members who are entitled to full benefits under Medicaid, these are benefits that you may be entitled to. These are additional Medicaid benefits that may not be covered by Cooperative Advantage.		
Family Planning Services – includes nurse midwife services, and prenatal care coordination for women with high-risk pregnancies	Covered Does not cover reversal of voluntary sterilization, infertility treatments, surrogate parenting, and related services.	
HealthCheck	HealthCheck is a Medicaid health care benefit created for young people (under 21). HealthCheck	

	covers in-depth exams and checkups. It also covers specialized services or products your child may need. The goal of HealthCheck is to prevent illnesses and find and treat health issues early.
Targeted Case Management	Covered
Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are Under 21 years of age, Under 22 years of age and was receiving services when you turned 21 years of age, or 65 years of age or older	Covered $3 copay per day with $75 cap per stay
Intermediate care facility services, other than services at an institution for mental disease	Covered
Some home and community-based services	Covered
Nursing services, including services performed by a nurse practitioner	Covered
Respiratory care services for ventilator-dependent individuals	Covered
Rural Health Clinic Services	Covered
Smoking Cessation Services	Covered
Tuberculosis (TB) Services	Covered

NON-DISCRIMINATION AND ACCESSIBILITY POLICY

Group Health Cooperative of Eau Claire complies with applicable Federal civil rights laws and do not discriminate, exclude or treat people differently on the basis of race, color, national origin, age, disability, sex, religion, political beliefs, sexual orientation, or filing of a prior civil rights complaint.

Group Health Cooperative of Eau Claire:

- 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 our Civil Rights Coordinator: 1-888-203-7770.

If you believe that Group Health Cooperative of Eau Claire has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, religion, political beliefs, sexual orientation, or filing of a prior civil rights complaint, you can file a grievance with:

Civil Rights Coordinator
2503 N. Hillcrest Pkwy
Altoona, WI 54720
Phone: 1-888-203-7770
Fax: 1-715-836-7683
TTY: 711
Email: compliance@group-health.com

If you need help filing a grievance, our Civil Rights 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, D.C. 20201
800-368-1019 (Voice), 800-537-7697 (TTY)
OCRComplaint@hhs.gov
https://www.hhs.gov/civil-rights

2023 | SUMMARY OF BENEFITS

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Group Health Cooperative of Eau Claire provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We also provide free language services to people whose primary language is not English, including qualified interpreters and information written in other languages. If you need these services, contact Member Services at: (888) 203-7770 (TTY: 711).

English – ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-888-203-7770 (TTY: 711).

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-203-7770 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-203-7770 (TTY: 711).

Chinese – 注意：**如果您**说中文，您可获得免费的语言协助服务。请致电 1-888-203-7770 (TTY **文字**电话: (TTY: 711).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-203-7770 (TTY: 711).

Arabic – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 888-302-0777 (رقم هاتف الصم والبكم711).

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-203-7770 (телетайп: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-203-7770 (TTY: 711)번으로 전화해 주십시오.

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-203-7770 (TTY: 711).

Pennsylvania Dutch – Wann du [Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-888-203-7770 (TTY: 711).

Laotian – ໂປດຊາບ: ຖ້າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການ ບໍລິການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາສາ, ໂດຍ ບໍ່ ເສັຽ ຄ່າ ທ່ານ ສາມາດ ໂທ 1-888-203-7770 (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-203-7770 (ATS : 711).

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-203-7770 (TTY: 711).

Hindi – ध्यान द�: यदि आप हिंदी बोलते ह� तो आपके लिए मु� म� भाषा सहायता सेवाएं उपल� ह�। 1-888-203- 7770 (TTY: 711) पर कॉल कर�।

Albanian – KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-203-7770 (TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-203-7770 (TTY: 711).

Somali – DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-888-203-7770 (TTY: 711).

Serbo-Croatian – OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-203-7770 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).