2022 Summary of Benefits

Premium (HMO I-SNP) | H7598

Cooperative™ ADVANTAGE

Cooperative ADVANTAGE

2022 | SUMMARY OF BENEFITS

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, 2022
- ☐ 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 an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that you, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities (ICF/IDD), or an inpatient psychiatric facility.
- ☐ This plan is an institutional special needs plan (I-SNP). Your ability to enroll will be based on verification that your condition makes it likely that either the length of stay or the need for an institutional level of care would be at least 90 days

This is a summary of health and prescription drug services covered by Cooperative Advantage (HMO I-SNP) January 1, 2022 - December 31, 2022.

Cooperative Advantage (HMO I-SNP) is a Medicare Advantage Health Maintenance Organization (HMO) Plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

2022 | 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 I-SNP) YOU:

- ➔ Must be entitled to Medicare Part A,
- ➔ And be enrolled in Medicare Part B,
- ➔ And live in our service area
- ➔ And reside in one of our contracted nursing facilities for greater than 90 days or reside in one of our assisted living facilities within our service area.

SERVICE AREA:

- ➔ Barron County
- ➔ Chippewa County
- ➔ Eau Claire County
- ➔ Trempealeau County

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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.

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 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 "Member & 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.

Cooperative ADVANTAGE

2022 | SUMMARY OF BENEFITS

You must continue to pay your Medicare Part B premium.

BENEFIT DESCRIPTION	**Cooperative Advantage** (HMO I-SNP)
Monthly Plan Premium	$75
Deductible – Part B	$0
	This is the 2021 Part B Deductible and may be subject to change per 2022 rates once released.
Maximum Out-of-Pocket Responsibility	$7,550
Inpatient Hospital Coverage*	• $295 copay Interval 1 (Day 1 - 6) • $0 copay Interval 2 (Day 7 - 90)
Outpatient Hospital Coverage* • Outpatient Blood Services • Observation* • Hospital outpatient surgeries*	20% Coinsurance
Ambulatory Surgery Center*	20% Coinsurance
Doctor Visits: • Primary Care Providers • Specialists	 • 20% Coinsurance • 20% Coinsurance
Preventive Care	No cost-share
Emergency Care	$90 Copayment
Urgently Needed Services	$65 Copayment
Diagnostic Services/Labs/ Imaging • Diagnostic tests and procedures • Labs • Diagnostic radiology • X-rays	20% Coinsurance
Hearing Services • Routine Hearing Exam • Medicare Hearing Exam • Hearing Aids	• 1 hearing exam per year • No cost-share • 1 set of hearing aids every 3 years up to $700 max, $250 copay per hearing aid

BENEFIT DESCRIPTION	**Cooperative Advantage** (HMO I-SNP)
Dental Services • Oral Exam, cleaning, x-rays	• 1 each per year, no cost-share
Vision Services	• 1 vision exam every two years • 1 set of glasses/frames $200 max per year
Mental Health Services • Outpatient Mental Health Services	• 20% Coinsurance
Skilled Nursing Facility* • Requires member to need daily skilled nursing and/or skilled rehabilitation services. Prior Authorization is required.	You pay the 2021 Original Medicare cost-sharing amounts. These amounts may be subject to change once the 2022 Medicare rates are released. • You pay nothing for the first 20 days of each benefit period. • You pay $185.50 per day for days 21-100. • You pay all costs for each day after day 100.
Physical Therapy, Occupational and Speech Therapy*	• 20% Coinsurance
Ambulance • Non-emergent*	• $225 Copay
Transportation	12 one-way per year, can't exceed 10 miles
Medicare Part B Drugs**	• 20% Coinsurance
Durable Medical Equipment	• 20% Coinsurance

* Service requires 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 only 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 of five "tiers." You will need to use your Formulary to locate what tier your drug is on to determine how much it will cost.

The amount you pay depends on the drug's tier and 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.

Our plan groups each medication into one of five "tiers." You will need to use your Formulary to locate what tier your drug is on to determine how much it will cost.

COOPERATIVE ADVANTAGE (HMO I-SNP)

Tier	Standard Retail		
	30 day	60 day	90 day
Tier 1 (Preferred Generic)	$2	$4	$6
Tier 2 (Generic)	$20	$40	$60
Tier 3 (Preferred Brand)	$45	$90	$135
Tier 4 (Non-Preferred Drug)	44%	44%	44%
Tier 3 (Specialty)	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	$1.35 (each prescription)	$4.00 (each prescription)
LIS 3	$3.95 (each prescription)	$9.85 (each prescription)
LIS 4	15% (each prescription)	15% (each prescription

NON-DISCRIMINATION AND ACCESSIBILITY POLICY

Group Health Cooperative of Eau Claire and KMTSJ, Inc. comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Group Health Cooperative of Eau Claire and KMTSJ, Inc. do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Group Health Cooperative of Eau Claire and KMTSJ, Inc.:

- 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 or KMTSJ, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, 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
TTD/TYY: 1-800-947-3529
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
Phone: 1-800-368-1019
TYY/TDD: 1-800-537-7697

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

Group Health Cooperative of Eau Claire complies with applicable Federal civil rights laws and does not discriminate on the basis of race, religion, color, national origin, age, disability, or sex.

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: 1 800 947 3529).

English – ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-888-203-7770 (TTY: 1-800-947-3529).

Spanish – ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-888-203-7770 (TTY: 1-800-947-3529).

Hmong – CEEB TOOM: Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-888-203-7770 (TTY: 1-800-947-3529).

Somali - DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-888-203-7770 (TTY: 1-800-947-3529).

Laotian - ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-888-203-7770 (TTY: 1-800-947-3529)

Chinese Mandarin - 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: 1-800-947-3529)
