Prevea360 Essential (HMO-POS) offered by Dean Health Plan

Annual Notice of Changes for 2023

You are currently enrolled as a member of Prevea360 Essential. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at prevea360.com/medicare. You may also call the Customer Care Center to ask us to mail you an *Evidence of Coverage*.)

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

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.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2023 Drug List to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals and other providers including pharmacies will be in our network next year.

☐ 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 Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2023* handbook.

☐ 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 don't join another plan by December 7, 2022, you will stay in **Prevea360 Essential.**
    - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2023**. This will end your enrollment with Prevea360 Essential.
    - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact the Customer Care Center number toll-free at 1-877-232-7566 for additional information. (TTY users should call 711.) Hours are 8 am to 8 pm, seven days per week. However, please note that our automated phone system may answer your call during all Federal holidays and weekends from April 1 to September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day.
- The Customer Care Center has free language interpreter services available for non-English speakers.
- This information is available for free in other formats. Please call the Customer Care Center 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 www.irs.gov/affordable-care-act/individuals-and-families for more information.

About Prevea360 Essential

- Dean Health Plan, Inc is a HMO/HMO-POS with a Medicare contract. Enrollment in Dean Health Plan, Inc. depends on contract renewal. Dean Health Plan markets under the names Dean Advantage and Prevea360 Medicare Advantage.
- When this document says "we," "us," or "our," it means Dean Health Plan. When it says "plan" or "our plan," it means Prevea360 Essential.

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Annual Notice of Changes for 2023
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Summary of Important Costs for 2023

The table below compares the 2022 costs and 2023 costs for Prevea360 Essential in several important areas. **Please note this is only a summary of costs.**

Cost	2022 (this year)	2023 (next year)
Monthly plan premium* *Your premium may be higher than this amount. See Section 1.1 for details. **Monthly Part B Premium Reduction** (You must also continue to pay your Medicare Part B premium.)	$0 $25	$0 $20
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.)	$4,500 for in-network services $6,000 for in-network and out-of-network services combined	$4,700 for in-network services $6,000 for in-network and out-of-network services combined
Doctor office visits	**Primary care visits:** **In-Network:** You pay $0 copay per visit **Out-of-Network:** You pay $50 copay per visit **Specialist visits:** **In-Network:** You pay $35 copay per visit **Out-of-Network:** You pay $50 copay per visit	**Primary care visits:** **In-Network:** You pay $0 copay per visit **Out-of-Network:** You pay $60 copay per visit **Specialist visits:** **In-Network:** You pay $35 copay per visit **Out-of-Network:** You pay $60 copay per visit

Cost	2022 (this year)	2023 (next year)
Inpatient hospital stays	**In-Network:** You pay $325 copay each day for days 1 - 5 You pay $0 each day for days 6 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days. **Out-of-Network:** You pay $500 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.	**In-Network:** You pay $350 copay each day for days 1 - 5 You pay $0 each day for days 6 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days. **Out-of-Network:** You pay $600 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.
Part D prescription drug coverage (See Section 1.5 for details.) You pay $30 per prescription at preferred pharmacies and $35 per prescription at standard retail pharmacies for insulins covered by our formulary.	Deductible: $250 applies to Tier 3, Tier 4 and Tier 5 Copayment/Coinsurance as applicable during the Initial Coverage Stage:	Deductible: $250 applies to Tier 3, Tier 4 and Tier 5 Copayment/Coinsurance as applicable during the Initial Coverage Stage:

Cost	2022 (this year)	2023 (next year)
To find out which insulins are covered, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call the Customer Care Center.	• **Drug Tier 1:** **Standard Cost-sharing:** You pay $7 per prescription **Preferred Cost-sharing:** You pay $0 per prescription	• **Drug Tier 1:** **Standard Cost-sharing:** You pay $7 per prescription **Preferred Cost-sharing:** You pay $2 per prescription
	• **Drug Tier 2:** **Standard Cost-sharing:** You pay $12 per prescription **Preferred Cost-sharing:** You pay $5 per prescription	• **Drug Tier 2:** **Standard Cost-sharing:** You pay $10 per prescription **Preferred Cost-sharing:** You pay $5 per prescription
	• **Drug Tier 3:** **Standard Cost-sharing:** You pay $47 per prescription **Preferred Cost-sharing:** You pay $40 per prescription	• **Drug Tier 3:** **Standard Cost-sharing:** You pay $47 per prescription **Preferred Cost-sharing:** You pay $42 per prescription
	• **Drug Tier 4:** **Standard Cost-sharing:** You pay $100 per prescription **Preferred Cost-sharing:** You pay $90 per prescription	• **Drug Tier 4:** **Standard Cost-sharing:** You pay $100 per prescription **Preferred Cost-sharing:** You pay $95 per prescription

Cost	2022 (this year)	2023 (next year)
	• **Drug Tier 5:** **Standard Cost-sharing:** You pay 28% of the total cost **Preferred Cost-sharing:** You pay 28% of the total cost	• **Drug Tier 5:** **Standard Cost-sharing:** You pay 29% of the total cost **Preferred Cost-sharing:** You pay 29% of the total cost
	• **Drug Tier 6:** **Standard Cost-sharing:** You pay $0 per prescription **Preferred Cost-sharing:** You pay $0 per prescription	• **Drug Tier 6:** **Standard Cost-sharing:** You pay $0 per prescription **Preferred Cost-sharing:** You pay $0 per prescription

To find out which insulins are covered, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call the Customer Care Center. (Phone numbers for the Customer Care Center are in Section 7.1 in this document.)

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2022 (this year)	2023 (next year)
Monthly premium	$0	$0
Monthly Part B Premium Reduction (You must also continue to pay your Medicare Part B premium.)	$25	$20

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as "creditable coverage") for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

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

Medicare requires all health plans to limit how much you pay "out-of-pocket" for 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	2022 (this year)	2023 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your plan premium and your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$4,500 for in-network services $6,000 for in-network and out-of-network services combined	$4,700 for in-network services $6,000 for in-network and out-of-network services combined Once you have paid $4,700 for in-network services or $6,000 for in-network and out-of-network services combined 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.

Section 1.3 – Changes to the Provider Network and Pharmacy Network

Updated directories are located on our website at prevea360.com/medicare. You may also call the Customer Care Center for updated provider and/or pharmacy information or to ask us to mail you a *directory*.

There are changes to our network of providers for next year. **Please review the 2023 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2023 Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact the Customer Care Center so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2022 (this year)	2023 (next year)
Screening for lung cancer with low dose computed tomography (LDCT)	Eligible members are aged 55 – 77 with 30 pack-year history of smoking.	Eligible members are aged 50 – 77 with 20 pack-year history of smoking.
Acupuncture: Medicare-Covered	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $50 copay	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $60 copay
Ambulance Services: Emergency Air	**In-Network:** You pay $275 copay **Out-of-Network:** You pay $275 copay	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
Ambulance Services: Non-Emergency Air	**In-Network:** You pay $275 copay **Out-of-Network:** You pay $275 copay	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 20% coinsurance
Cardiac Rehabilitation Services	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $30 copay **Out-of-Network:** You pay $60 copay
Cardiac Rehabilitation Services: Intensive Cardiac Rehab	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $30 copay **Out-of-Network:** You pay $60 copay
Chiropractic Services: Medicare-Covered	**In-Network:** You pay $15 copay **Out-of-Network:** You pay $50 copay	**In-Network:** You pay $20 copay **Out-of-Network:** You pay $60 copay

Cost	2022 (this year)	2023 (next year)
Chiropractic Services: Routine Care	**In-Network:** You pay $15 copay per visit for 24 visits every calendar year **Out-of-Network:** You pay $50 copay per visit for combined 24 visits every calendar year	**In-Network:** You pay $20 copay per visit for 12 visits every calendar year **Out-of-Network:** You pay $60 copay per visit for combined 12 visits every calendar year
Chiropractic Services: Therapeutic Services	**In-Network:** You pay $15 copay per visit for 6 visits every calendar year **Out-of-Network:** You pay $50 copay per visit for combined 6 visits every calendar year	**In-Network:** You pay $20 copay per visit for 6 visits every calendar year **Out-of-Network:** You pay $60 copay per visit for combined 6 visits every calendar year
Dental: Medicare-Covered	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $50 copay	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $60 copay
Dental: Comprehensive Periodontics	**In-Network:** You pay $95 copay **Out-of-Network:** Not Covered	**In-Network:** You pay $595 copay **Out-of-Network:** Not Covered
Emergency Care in the U.S.	**In-Network:** You pay $90 copay **Out-of-Network:** You pay $90 copay	**In-Network:** You pay $95 copay **Out-of-Network:** You pay $95 copay
Hearing Services: Medicare-Covered Exam	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $60 copay

Cost	2022 (this year)	2023 (next year)
In-Home Support	**In-Network:** You pay $0 copay per visit for 10 hours every month **Out-of-Network:** Not Covered	**In-Network:** You pay $0 copay per visit for 120 hours yearly **Out-of-Network:** Not Covered
Inpatient Hospital Care	**In-Network:** You pay $325 copay each day for days 1 - 5 You pay $0 each day for days 6 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days. **Out-of-Network:** You pay $500 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.	**In-Network:** You pay $350 copay each day for days 1 - 5 You pay $0 each day for days 6 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days. **Out-of-Network:** You pay $600 copay each day for days 1 - 7 You pay $0 each day for days 8 to discharge Cost-sharing is applied for each inpatient stay. You are covered for an unlimited number of medically necessary inpatient hospital days.

Cost	2022 (this year)	2023 (next year)
Inpatient Psychiatric Hospital Care	**In-Network:** You pay $325 copay each day for days 1 - 5 You pay $0 each day for days 6 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period. **Out-of-Network:** You pay $500 copay each day for days 1 - 7 You pay $0 each day for days 8 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period.	**In-Network:** You pay $350 copay each day for days 1 - 5 You pay $0 each day for days 6 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period. **Out-of-Network:** You pay $600 copay each day for days 1 - 7 You pay $0 each day for days 8 - 90 Cost-sharing is applied for each inpatient stay. Coverage is limited to 90 days per benefit period.
Outpatient Diagnostic Tests	**In-Network:** You pay $0 copay **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay $25 copay **Out-of-Network:** You pay 20% coinsurance
Outpatient Diagnostic Radiology Services	**In-Network:** You pay $100 copay for diagnostic radiology You pay $0 copay for diagnostic mammograms **Out-of-Network:** You pay 20% coinsurance for diagnostic radiology You pay 20% coinsurance for diagnostic mammograms	**In-Network:** You pay $150 copay for diagnostic radiology You pay $0 copay for diagnostic mammograms **Out-of-Network:** You pay 40% coinsurance for diagnostic radiology You pay 40% coinsurance for diagnostic mammograms

Cost	2022 (this year)	2023 (next year)
Outpatient Therapeutic Radiology Services	**In-Network:** You pay $35 copay **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay 20% coinsurance **Out-of-Network:** You pay 40% coinsurance
Outpatient Diagnostic X-Ray	**In-Network:** You pay $30 copay **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay $30 copay **Out-of-Network:** You pay 40% coinsurance
Outpatient Hospital Observation Services	**In-Network:** You pay $275 copay **Out-of-Network:** You pay 20% coinsurance	**In-Network:** You pay $350 copay **Out-of-Network:** You pay 40% coinsurance
Outpatient Mental Health Care: Individual Therapy (Non-Physician)	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay
Outpatient Mental Health Care: Group Therapy (Non-Physician)	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay
Outpatient Mental Health Care: Individual Therapy (Psychiatrist)	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay
Outpatient Mental Health Care: Group Therapy (Psychiatrist)	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay
Outpatient Rehabilitation Services: Occupational Therapy	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $60 copay	**In-Network:** You pay $40 copay **Out-of-Network:** You pay $60 copay

Cost	2022 (this year)	2023 (next year)
Outpatient Rehabilitation Services: Physical Therapy and Speech Therapy	**In-Network:** You pay $35 copay per visit **Out-of-Network:** You pay $60 copay per visit	**In-Network:** You pay $40 copay per visit **Out-of-Network:** You pay $60 copay per visit
Outpatient Substance Abuse Services: Group Therapy	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay	**In-Network:** You pay $20 copay **Out-of-Network:** You pay $60 copay
Outpatient Surgery: Outpatient Hospital	**In-Network:** You pay $275 copay for outpatient hospital surgery You pay $0 copay for screening colonoscopies that result in biopsy or removal of any growth during the procedure Minor surgical services performed during an office visit will only be charged physician services cost-sharing **Out-of-Network:** You pay 20% coinsurance for outpatient hospital surgery You pay 20% coinsurance for screening colonoscopies that result in biopsy or removal of any growth during the procedure	**In-Network:** You pay $350 copay for outpatient hospital surgery You pay $0 copay for screening colonoscopies that result in biopsy or removal of any growth during the procedure Minor surgical services performed during an office visit will only be charged physician services cost-sharing **Out-of-Network:** You pay 40% coinsurance for outpatient hospital surgery You pay 40% coinsurance for screening colonoscopies that result in biopsy or removal of any growth during the procedure

Cost	2022 (this year)	2023 (next year)
Outpatient Surgery: Ambulatory Surgical Center	**In-Network:** You pay $175 copay for ambulatory surgical center services You pay $0 copay for screening colonoscopies that result in biopsy or removal of any growth during the procedure Minor surgical services performed during an office visit will only be charged physician services cost-sharing **Out-of-Network:** You pay 20% coinsurance for ambulatory surgical center services You pay 20% coinsurance for screening colonoscopies that result in biopsy or removal of any growth during the procedure	**In-Network:** You pay $300 copay for ambulatory surgical center services You pay $0 copay for screening colonoscopies that result in biopsy or removal of any growth during the procedure Minor surgical services performed during an office visit will only be charged physician services cost-sharing **Out-of-Network:** You pay 40% coinsurance for ambulatory surgical center services You pay 40% coinsurance for screening colonoscopies that result in biopsy or removal of any growth during the procedure

Cost	2022 (this year)	2023 (next year)
Part B Drugs	**In-Network:** You pay 20% coinsurance for intravenous, subcutaneous, and biological Part B drugs You pay $0 - $47 copay for Part B prescription drugs received in the pharmacy **Out-of-Network:** You pay 20% coinsurance for intravenous, subcutaneous, and biological Part B drugs You pay 20% coinsurance for Part B prescription drugs received in the pharmacy	**In-Network:** You pay 20% coinsurance for intravenous, subcutaneous, and biological Part B drugs You pay $2 - $47 copay for Part B prescription drugs received in the pharmacy Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance beginning on April 1, 2023. For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one month supply effective July 1, 2023. **Out-of-Network:** You pay 20% coinsurance for intravenous, subcutaneous, and biological Part B drugs You pay 20% coinsurance for Part B prescription drugs received in the pharmacy Beneficiary coinsurance for certain Part B rebatable drugs may be subject to a lower coinsurance beginning on April 1, 2023. For Part B insulin furnished through an insulin pump, you will pay no more than a $35 copay for a one month supply effective July 1, 2023.

Cost	2022 (this year)	2023 (next year)
Partial Hospitalization Services	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $100 copay	**In-Network:** You pay $70 copay **Out-of-Network:** You pay $100 copay
Physician Services: Primary Care Physician	**In-Network:** You pay $0 copay per visit **Out-of-Network:** You pay $50 copay per visit	**In-Network:** You pay $0 copay per visit **Out-of-Network:** You pay $60 copay per visit
Physician Services: Specialist Physician	**In-Network:** You pay $35 copay per visit **Out-of-Network:** You pay $50 copay per visit	**In-Network:** You pay $35 copay per visit **Out-of-Network:** You pay $60 copay per visit
Podiatry Services: Medicare-Covered	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $50 copay	**In-Network:** You pay $40 copay **Out-of-Network:** You pay $60 copay
Podiatry Services: Routine Footcare	**In-Network:** You pay $35 copay per visit for 10 visits every calendar year **Out-of-Network:** You pay $50 copay per visit for combined 10 visits every calendar year	**In-Network:** You pay $40 copay per visit for 10 visits every calendar year **Out-of-Network:** You pay $60 copay per visit for combined 10 visits every calendar year
Pulmonary Rehabilitation Services	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $60 copay

Cost	2022 (this year)	2023 (next year)
Skilled Nursing Facility	**In-Network:** You pay $0 copay each day for days 1 - 20 You pay $184 copay each day for days 21 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period. **Out-of-Network:** You pay $150 copay each day for days 1 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period.	**In-Network:** You pay $0 copay each day for days 1 - 20 You pay $196 copay each day for days 21 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period. **Out-of-Network:** You pay $150 copay each day for days 1 - 100 Cost-sharing is applied per benefit period. Coverage is limited to 100 days per benefit period.
Supervised Exercise Therapy for Peripheral Arterial Disease	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $30 copay **Out-of-Network:** You pay $60 copay
Vision Care: Medicare-Covered Exam	**In-Network:** You pay $0 copay **Out-of-Network:** You pay $30 copay	**In-Network:** You pay $35 copay **Out-of-Network:** You pay $60 copay
Vision Care: Eyewear Allowance	**In-Network:** We cover $200 every calendar year **Out-of-Network:** Not Covered	**In-Network:** Not Covered **Out-of-Network:** Not Covered

Cost	2022 (this year)	2023 (next year)
Worldwide Emergency Coverage	**In-Network:** You pay $90 copay Annual Limit for Worldwide Care services: No Limit **Out-of-Network:** You pay $90 copay Annual Limit for Worldwide Care services: No Limit	**In-Network:** You pay $95 copay Annual Limit for Worldwide Care services: No Limit **Out-of-Network:** You pay $95 copay Annual Limit for Worldwide Care services: No Limit
Worldwide Urgent Coverage	**In-Network:** You pay $90 copay **Out-of-Network:** You pay $90 copay	**In-Network:** You pay $95 copay **Out-of-Network:** You pay $95 copay

Section 1.5 – 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 the Customer Care Center (see Section 7.1) or visiting our website prevea360.com/medicare.

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.**

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. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online Drug List to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact the Customer Care Center for more information.

We have made changes to the list of insulin drugs that will be covered. To find out which drugs are covered Insulins, review the most recent Drug List we provided electronically. If you have questions about the Drug List, you can also call the Customer Care Center. (Phone numbers for the Customer Care Center are in Section 7.1 in this document.)

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 sent 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 you haven't received this insert by 9/30/2022, please call the Customer Care Center and ask for the "LIS Rider."

There are four "drug payment stages."

The information below shows the changes 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.)

Changes to the Deductible Stage

Stage	2022 (this year)	2023 (next year)
Stage 1: Yearly Deductible Stage During this stage, **you pay the full cost** of your Tier 3, Tier 4 and Tier 5 drugs in 2023 until you have reached the yearly deductible. There is no deductible for Prevea360 Essential for insulins covered on our formulary. You pay $30 per prescription at preferred pharmacies and $35 per prescription at standard retail pharmacies for covered insulins.	The deductible is $250. **Tier 1:** **Standard Cost Sharing:** You pay $7 per prescription **Preferred Cost Sharing:** You pay $0 per prescription **Tier 2:** **Standard Cost Sharing:** You pay $12 per prescription **Preferred Cost Sharing:** You pay $5 per prescription **Tier 3:** You pay full cost of your drugs until you have reached the yearly deductible **Tier 4:** You pay full cost of your drugs until you have reached the yearly deductible **Tier 5:** You pay full cost of your drugs until you have reached the yearly deductible **Tier 6:** **Standard Cost Sharing:** You pay $0 per prescription **Preferred Cost Sharing:** You pay $0 per prescription	The deductible is $250. **Tier 1:** **Standard Cost Sharing :** You pay $7 per prescription **Preferred Cost Sharing:** You pay $2 per prescription **Tier 2:** **Standard Cost Sharing :** You pay $10 per prescription **Preferred Cost Sharing:** You pay $5 per prescription **Tier 3:** You pay full cost of your drugs until you have reached the yearly deductible **Tier 4:** You pay full cost of your drugs until you have reached the yearly deductible **Tier 5:** You pay full cost of your drugs until you have reached the yearly deductible **Tier 6:** **Standard Cost Sharing:** You pay $0 per prescription **Preferred Cost Sharing:** You pay $0 per prescription

Changes to Your Cost-Sharing in the Initial Coverage Stage

Stage	2022 (this year)	2023 (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 that provides standard cost-sharing. **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. You pay $30 per prescription at preferred pharmacies and $35 per prescription at standard retail pharmacies for insulins covered on our formulary.	Your cost for a retail one-month supply filled at a network pharmacy **Tier 1:** **Standard Cost Sharing:** You pay $7 per prescription **Preferred Cost Sharing:** You pay $0 per prescription	Your cost for a retail one-month supply filled at a network pharmacy **Tier 1:** **Standard Cost Sharing:** You pay $7 per prescription **Preferred Cost Sharing:** You pay $2 per prescription
	Tier 2: **Standard Cost Sharing:** You pay $12 per prescription **Preferred Cost Sharing:** You pay $5 per prescription	**Tier 2:** **Standard Cost Sharing:** You pay $10 per prescription **Preferred Cost Sharing:** You pay $5 per prescription
	Tier 3: **Standard Cost Sharing:** You pay $47 per prescription **Preferred Cost Sharing:** You pay $40 per prescription	**Tier 3:** **Standard Cost Sharing:** You pay $47 per prescription **Preferred Cost Sharing:** You pay $42 per prescription

	Tier 4: **Standard Cost Sharing:** You pay $100 per prescription **Preferred Cost Sharing:** You pay $90 per prescription	**Tier 4:** **Standard Cost Sharing:** You pay $100 per prescription **Preferred Cost Sharing:** You pay $95 per prescription
	Tier 5: **Standard Cost Sharing:** You pay 28% of the total cost **Preferred Cost Sharing:** You pay 28% of the total cost	**Tier 5:** **Standard Cost Sharing:** You pay 29% of the total cost **Preferred Cost Sharing:** You pay 29% of the total cost
	Tier 6: **Standard Cost Sharing:** You pay $0 per prescription **Preferred Cost Sharing:** You pay $0 per prescription _____ Once your total drug costs have reached $4,430 you will move to the next stage (the Coverage Gap Stage).	**Tier 6:** **Standard Cost Sharing:** You pay $0 per prescription **Preferred Cost Sharing:** You pay $0 per prescription _____ Once your total drug costs have reached $4,660 you will move to the next stage (the Coverage Gap Stage).

Prevea360 Essential offers additional gap coverage for insulins covered on our formulary. During the Coverage Gap stage, your out-of-pocket costs for select insulins will be $30 per prescription at preferred pharmacies and $35 per prescription at standard retail pharmacies.

Prevea360 Essential offers $0 Tier 1 and Tier 2 three-month supplies through Costco mail-order pharmacy. You do not need to be a Costco member to access the pharmacy.

- **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call the Customer Care Center for more information.
- **Important Message About What You Pay for Insulin -** You won't pay more than $30 at preferred pharmacies or $35 at standard retail pharmacies for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible.
- **Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at $35 a month or less, it is important to know that you may have other options available to you for 2023 at even lower costs because of changes to the Medicare Part D program. Contact Medicare, at 1-800- MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for help comparing your options. TTY users should call 1-877-486-2048**.
- **Additional Resources to Help** – Please contact our Customer Care Center for additional information at 1-877-232-7566 toll-free. TTY only, call 711. We are available for phone calls from 8 am to 8 pm. However, please note that our automated phone system may answer your call during all Federal holidays and weekends from April 1 to September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Calls to 1-877-232-7566 and TTY 711 are free.

SECTION 2 Administrative Changes

Benefit	2022 (this year)	2023 (next year)
Quantity in a 3 month supply of drugs	Drugs eligible for 3 month fills receive a 90 day supply	Drugs eligible for 3 month fills receive a 100 day supply
Fitness Benefit	Silver&Fit	One Pass™ Fitness Program
Living Healthy Rewards powered by WebMD	Up to $150 in earned rewards could be redeemed for gift cards. (Includes Amazon.)	Up to $150 in earned rewards will be loaded on Your Prevea360 Wallet card. Swipe it at many stores, restaurants, and gas stations to redeem your rewards. (Does not include Amazon.)

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in Prevea360 Essential

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 by December 7, you will automatically be enrolled in our Prevea360 Essential.

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 plans for 2023 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. If you do not enroll in a Medicare drug plan, please see Section **1.1** regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2023* handbook, call your State Health Insurance Assistance Program (SHIP) (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Dean Health Plan 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 Prevea360 Essential.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from Prevea360 Essential.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll. Contact the Customer Care Center if you need more information on how to do so.
    - – *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.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2023.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include 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.

If you enrolled in a Medicare Advantage plan for January 1, 2023, 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, 2023.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. The State Health Insurance Assistance Program in your area is:

- Wisconsin: Board on Aging and Long Term Care (BOALTC)

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare.

SHIP 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. Call them or learn more by visiting their website:

Method	**Wisconsin SHIP: Board on Aging and Long Term Care– Contact Information**
CALL	1-800-242-1060
WRITE	State of Wisconsin - Board on Aging & Long Term Care 1402 Pankratz Street, Suite 111 Madison, Wisconsin 53704-4001

Method	Wisconsin SHIP: Board on Aging and Long Term Care– Contact Information
WEBSITE	http://longtermcare.wi.gov

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.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, 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 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778 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.
- **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 State AIDS/HIV Drug Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call your State ADAP office listed below.

Method	Wisconsin: Wisconsin AIDS/HIV Drug Assistance Program (ADAP) – Contact Information
CALL	1-800-991-5532 Hours of operation are 8 am to 5 pm Monday through Friday
WRITE	Wisconsin AIDS/HIV Drug Assistance Program 1 West Wilson St, Madison, WI 53703

Method	Wisconsin: Wisconsin AIDS/HIV Drug Assistance Program (ADAP) – Contact Information
WEBSITE	www.dhs.wisconsin.gov/hiv/adap.htm

SECTION 7 Questions?

Section 7.1 – Getting Help from Prevea360 Essential

Questions? We're here to help. Please call the Customer Care Center 1-877-232-7566 toll-free. TTY only, call 711. We are available for phone calls from 8 am to 8 pm. However, please note that our automated phone system may answer your call during all Federal holidays and weekends from April 1 to September 30. Please leave your name and telephone number, and we'll call you back by the end of the next business day. Calls to 1-877-232-7566 and TTY 711 are free.

Read your 2023 *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 2023. For details, look in the 2023 *Evidence of Coverage* for Prevea360 Essential. 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. The *Evidence of Coverage* is located on our website at prevea360.com/medicare. You may also call the Customer Care Center for information or to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at prevea360.com/medicare. 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

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. (To view the information about plans, go to www.medicare.gov/plan-compare).

Read *Medicare & You 2023*

Read the *Medicare & You 2023* handbook. Every fall, this document 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 document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) 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.

Non-Discrimination & Language Assistance Access

For assistance understanding these materials in a language other than English, call 1-877-317-2410 (TTY: 711), and a Customer Care Center representative will assist you.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sex, or religion. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, or religion.

We provide 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, or other formats).

We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, or religion, you can file a grievance with the organization's Civil Rights Coordinator. If you need help filing a grievance, the Civil Rights Coordinator for the Health Plan is available to help you. You can file a written grievance in person, by mail, or by email at:

Civil Rights Coordinator
1277 Deming Way
Madison, Wisconsin 53717
1-608-828-2216 (TTY: 711)
civilrightscoordinator@deancare.com

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, by mail, or phone at:
U.S. Department of Health and Human Services
200 Independence Ave, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

For help to translate or understand this or other documents, please call 1-877-317-2410 (TTY: 711).

Español: tenemos servicios gratuitos de interpretación para responder a cualquier consulta sobre nuestro plan de atención médica o de cobertura de medicamentos. Para solicitar un intérprete, llame al 1-877-317-2410 (TTY:711). Un hablante de español puede ayudarle. Este servicio es gratuito.

Somali- Waxaan bixinaa adeegyada bilaashka ah si looga jawaabo su'aalo kasta ood ka qabi karto caymiskaaga caafimaadka ama daawada. Si aad u hesho turjumaan, keliya nagasoo wac 1-877-317-2410 (TTY: 711), Qof ku hadla luuqada af-Soomaaliga ayaa ku caawin kara. Kani waa adeeg bilaash ah.

Tagalog- Mayroon kaming mga libreng serbisyo ng interpreter para sagutin ang anumang tanong na maaaring mayroon ka tungkol sa aming plano sa kalusugan o gamot. Para makakuha ng interpreter, tumawag lamang sa amin sa 1-877-317-2410 (TTY: 711). Matutulungan ka ng isang taong nagsasalita ng Tagalog. Isa itong libreng serbisyo.

Gujarati- અમારી સ્વાસ્થ્ય કે દવા યોજના વિશે જો આપને કોઈ પ્રશ્ન હોય તો તેનો જવાબ આપવા અમારી પાસે મફત દુભાષિયા સેવા ઉપલબ્ધ છે. ગુજરાતી બોલીને આપને મદદ કરી શકે એવો દુભાષિયો મેળવવા માટે, માત્ર અમને 1-877-317-2410 (TTY: 711) પર કોલ કરો. આ મફત સેવા છે.

Hindi- हमारे पास हमारे स्वास्थ्य या औषधि योजना से संबंधित आपके किसी भी प्रश्न का उत्तर देने के लिए नि:शुल्क दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-317-2410 (TTY: 711)

पर कॉल करें, कोई व्यक्ति जो हिंदी बोलता है, आपकी मदद कर सकता है। यह एक निःशुल्क सेवा है।

Hmong- Peb muaj cov kws txhais lus dawb los teb txhua nqi lus nug uas koj muaj hais txog peb li phiaj xwm kho mob los sis tshuaj muaj yees. Txhawm rau muaj tus kws pab txhais lus, thov hu rau peb tus xov tooj 1-877-317-2410 (TTY: 711), Yuav muaj tus hais ua lus Hmoob pab koj. No yog kev pab dawb.

Polish- Oferujemy bezpłatne usługi tłumacza, aby móc odpowiedzieć na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub planu lekowego. Aby skorzystać z pomocy tłumacza, wystarczy zadzwonić pod numer 1-877-317-2410 (TTY: 711). Osoba, która mówi po polsku, udzieli Państwu pomocy. Usługa jest bezpłatna.

Korean- 저희의 무료 통역 서비스를 통해 당사의 의료 보험 또는 의약품 보험에 대해 알고 싶으신 점을 질문하시고 답변을 받으십시오. 통역사가 필요하실 때는 1-877-317-2410 (TTY: 711)으로 전화 주십시오. 한국어가 가능한 직원이 도움을 드릴 것입니다. 무료로 이용하실 수 있습니다.

Russian- Мы предоставляем бесплатные услуги устного перевода, чтобы ответить на любые вопросы о нашем плане медицинского страхования или плане страхования стоимости лекарств. Чтобы получить помощь русского переводчика, просто позвоните по номеру 1-877-317-2410 (TTY: 711). Эта услуга является бесплатной.

French- Nous proposons des services d'interprétation gratuits pour répondre à toutes vos questions à propos de notre régime d'assurance maladie ou d'assurance médicaments. Pour bénéficier d'un(e) interprète, appelez simplement le 1 877 317 2410 (TTY: 711). Une personne parlant français pourra vous aider. Ce service est gratuit.

Italian- Offriamo servizi gratuiti di interpretazione per rispondere a eventuali domande in merito alla nostra assicurazione sanitaria o al nostro piano farmacologico. Per avvalersi dell'aiuto di un interprete in lingua italiana, chiamare il numero 1-877-317-2410 (TTY: 711). Il servizio è gratuito.

Chinese- 我们提供免费的口译服务，可回答您关于我们健康或药物计划的任何疑问。如需安排口译员，请致电 1-877-317-2410 (TTY: 711) 与我们联系，申请安排说中文的人员为您提供协助。此为免费服务。

Vietnamese- Chúng tôi có dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi của quý vị về chương trình bảo hiểm sức khỏe hoặc thuốc. Nếu quý vị cần thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-877-317-2410 (TTY: 711), sẽ có nhân viên nói tiếng Việt có thể hỗ trợ quý vị. Đây là dịch vụ miễn phí.

Arabic-

لدينا خدمات مترجم فوري للإجابة ىع أي أسئلة قد تكون لديك حول خطتنا الدوائية أو الصحية. للحصول على مترجم فوري، فقط اتصل بنا على الرقم 1-877-317-2410، وستجد امصّخش يتحدث اللغة العربية يمكن أن يساعدك. هذه هي خدمة مجانية.

German- Wir bieten einen kostenlosen Dolmetscher-Service für Sie an, damit wir Ihre Fragen bezüglich unseres Gesundheits- oder Medikationsplans beantworten können. Rufen Sie uns einfach unter der Nummer 1 877 317 2410 (TTY: 711) an, um einen Dolmetscher anzufordern. Ihnen wird dann auf Deutsch weitergeholfen. Dies ist ein kostenloser Service.

Urdu-

ہمارے ہیلتھ یا ڈرگ پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات دستیاب ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں صرف 1-877-317-2410 (TTY: 711) پر کال کریں، اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت سروس ہے۔