network health

2024

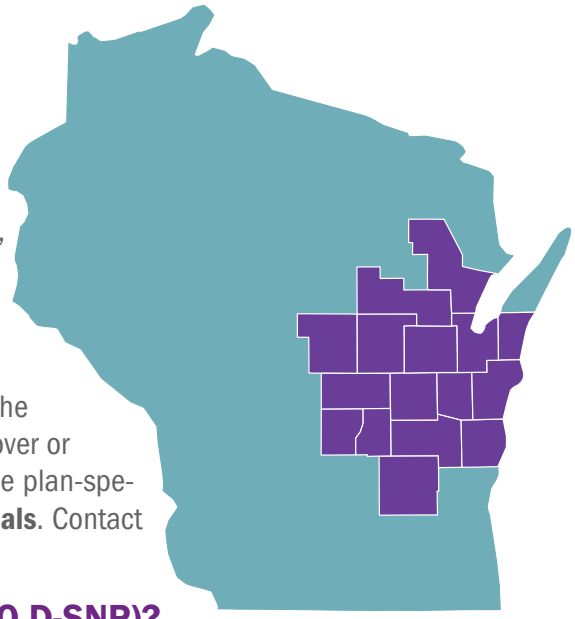
Network Health Cares Dual-Eligible Special Needs Plan (PPO D-SNP)

Summary of Benefits

2024 NETWORK HEALTH CARES (PPO D-SNP)

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 Health 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 Health Cares (PPO D-SNP) plan. It doesn't list every service we cover or 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.

SUMMARY OF BENEFITS

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (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 2023 the amounts were: $0-$226 depending on your level of Medicaid eligibility. These amounts may change for 2024.	
Annual Maximum Out-of-Pocket– (Does not include Part D prescription drugs)	$8,300 for services you receive from in-network providers $12,450 for services you receive from any provider, your limit for services received from in-network providers will count toward this limit	
Hospital Services		
Inpatient Hospital Services[1]– Per admission	In 2023 the amounts for each admission were: Days 1-60: $0-$1,600 deductible Days 61-90: $0-$400 per day Days 91 and beyond: $0-$800 per day (This plan covers 60 lifetime reserve days) These amounts may change for 2024.	Covered
Outpatient Hospital	0%-20% of the cost	Covered
Ambulatory Surgical Center	0%-20% of the cost	Covered
General Services		
Primary Care Provider Visit	0%-20% of the cost	Covered
Specialist Visit	0%-20% of the cost	Covered
Preventive Care		
Preventive Care Visits*	$0 in-network 0%-20% of the cost out-of-network	Covered
Annual Routine Physical	Not Covered	Covered
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit	Covered
Medicare-Covered Vaccines– Flu, pneumonia, COVID-19	$0 in-network 20% of the cost out-of-network	Covered
Medicare-Covered Vaccines– Hepatitis B, all other Part B	$0 in-network 0%-20% of the cost out-of-network	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.

Services with a [1] may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit. 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.

2024 NETWORK HEALTH CARES (PPO D-SNP)

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (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.	
Emergency Care		
Emergency Room Visit	0%-20% of the cost, up to $95	Coverage may not be available outside the state of Wisconsin
Urgent Care		
Urgent Care Visit– Free-standing facility	0%-20% of the cost, up to $60	Covered
Diagnostic Services		
Diagnostic Tests[1]– Such as ultrasound, EKG, stress test	0%-20% of the cost	Covered
Labs– What you pay may be based on the service received and/or where you are treated	0%-20% of the cost	Covered
Diagnostic Radiology Services– Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	0%-20% of the cost	Covered
X-rays	0%-20% of the cost	Covered
Hearing Services		
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
Hearing Aids[2]– Maximum of two hearing aids per year Hearing aid evaluation with TruHearing, fitting included	$495-$1,695 per device, hearing aids must be purchased through TruHearing	Covered
Dental Services		
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 $0 for major services received at in-network providers (endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery, other services), 50% coverage out-of-network $3,000 Annual Maximum	Covered

Services with a [1] may require prior authorization.
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SUMMARY OF BENEFITS

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (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.	
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
Vision Services		
Annual Routine Vision Exam[2]	$0 in-network, or $40 reimbursement	Covered
Diagnostic Eye Exam– To diagnose and treat diseases and conditions of the eye	0%-20% of the cost	Covered
Post-Cataract Eyewear[2]– One pair of eyeglasses or contact lenses after each cataract surgery	0%-20% of the cost	Covered
Additional Eyewear[2]– At EyeMed providers	$400 allowance in-network, or $400 reimbursement out-of-network	Covered
Mental Health/Substance Abuse		
Outpatient Mental Health– Individual or group therapy	0%-20% of the cost	Covered
Inpatient Mental Health[1]– Per admission	In 2023 the amounts for each admission were: Days 1-60: $0-$1,600 deductible Days 61-90: $0-$400 per day Days 91 and beyond: $0-$800 per day (This plan covers 60 lifetime reserve days) These amounts may change for 2024.	Covered
Opioid Treatment Services	0%-20% of the cost	Covered
Substance Abuse Services– Outpatient individual or group therapy	0%-20% of the cost	Covered
Continued Care Services		
Skilled Nursing Facility[1]– Per admission Once you reach your maximum out-of-pocket, you will pay $0 per day	In 2023 the amounts were: $0 per day, days 1-20 $0-$200 per day, days 21-100 These amounts may change for 2024.	Covered
Outpatient Physical[1], Occupational[1], Speech Therapy	0%-20% of the cost	Covered
Transportation Services		
Air and Ground Ambulance Services	0%-20% of the cost	Covered

Services with a [1] may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit. 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.

2024 NETWORK HEALTH CARES (PPO D-SNP)

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (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.	
Non-Emergency Transportation– One-way trips with Aryv	36 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
Drug Coverage		
Medicare Part B Drugs[1]– Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act.	0%-20% of the cost	Covered
Medicare Part D Drugs– See page 9-12 for specific drug tier costs	Covered	Covered
Additional Benefits		
Over-the-Counter Catalog	$175 per quarter Two orders per quarter No rollover on quarterly allowance	Limited coverage
Fitness with SilverSneakers®[2]	Included	Not covered
MDLIVE® Virtual Visit– For medical services[2]	$0	Not covered
Meal Delivery– Following a hospital observation stay, qualified inpatient hospital stay or skilled nursing facility stay	28 meals	Not covered
Fresh Produce or Pantry Boxes– For members screened by their care manager and diagnosed with diabetes, congestive heart failure or obesity	6 boxes annually	Not covered
In-Home Support– Assistance with organization, light housework, technology and transportation	60 hours annually	Not covered
HRA Rewards	Earn a $50 reward by completing your annual health risk assessment	Not 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

Services with a [1] may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit. 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.

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (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.	
International Emergency Coverage– View the Evidence of Coverage for details at networkhealth.com/medicare/plan-materials	$110 per incident $100,000 Maximum benefit	Not covered
Recovery and Rehabilitation Services		
Durable Medical Equipment– Such as insulin pumps[1], CPAP machines[1], prosthetic devices[1]	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
Cancer Services		
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 have severe nausea and/or vomiting	$0	Not covered
Diabetic Services		
Diabetes Monitoring Supplies and Test Strips– OneTouch™ and Accu-Chek™ test strips Continuous Glucose Monitoring supplies limited to eligible FreeStyle Libre® and Dexcom® obtained through your pharmacy All other brands are not covered	0%-20% of the cost	Covered – One Touch Not covered – Accu-Chek
Diabetic Shoe Inserts– Copayment per pair	0%-20% of the cost	Covered

Services with a [1] may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit. 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.

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (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.	
Diabetes Management Tool– Diabetes self-management training teaches you to cope with and manage your diabetes.	0%-20% of the cost	Not covered
Part B Insulin– One-month supply	0%-20% of the cost, up to $35	Covered
Renal Services		
Dialysis– Per treatment	0%-20% of the cost	Covered

PRESCRIPTION DRUG BENEFITS

Your Drug Costs	Network Health 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: $545 • Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs

Services with a [1] may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit. 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.

Your Drug Costs

INITIAL COVERAGE **PREFERRED RETAIL** COST-SHARING

After you reach your yearly deductible of $0-$545 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	**1-month supply** For generic drugs (including brand drugs treated as generic), either:	**3-month supply** 100-day for Tier 1 90-day for Tiers 2-4 For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $7 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $17 copayment
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $13 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $32 copayment
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $42 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $105 copayment
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $95 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $237 copayment
Tier 5 (Specialty)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or 25% of the cost	Not offered

Your Drug Costs

INITIAL COVERAGE **STANDARD RETAIL** COST-SHARING

After you reach your yearly deductible of $0-$545 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	**1-month supply** For generic drugs (including brand drugs treated as generic), either:	**3-month supply** 100-day for Tier 1 90-day for Tiers 2-4 For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $15 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $37 copayment
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $20 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $50 copayment
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $47 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $117 copayment
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $100 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $250 copayment
Tier 5 (Specialty)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or 25% of the cost	Not offered

Your Drug Costs

INITIAL COVERAGE **MAIL ORDER** COST-SHARING

After you reach your yearly deductible of $0-$545 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	**1-month supply** For generic drugs (including brand drugs treated as generic), either:	**3-month supply** 100-day for Tier 1 90-day for Tiers 2-4 For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $7 copayment	$0 copayment for 31-100 day mail order
Tier 2 (Generics and Non-Preferred Generics)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment; or • $13 copayment	$0 copayment for 31-90 day mail order
Tier 3 (Non-Preferred Generics and Preferred Brands)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $42 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $105 copayment
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $95 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $237 copayment
Tier 5 (Specialty)	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or 25% 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 customer service because you may pay more than you pay at an in-network pharmacy.

Part D Insulin and Vaccines		
Part D Insulin– One-month supply	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $35 copayment	• $0 copayment; or • $1.55 copayment; or • $4.50 copayment For all other drugs, either: • $0 copayment; or • $4.60 copayment; or • $11.20 copayment; or • $35 copayment
Part D Vaccines– Shingrix, Tdap, all other ACIP recommended vaccines	$0	$0

COVERAGE GAP

You enter the coverage gap when your total drug costs reach $5,030. You pay 25% and Network Health pays 75% for generic drugs. For brand name drugs, you pay 25%, Network Health pays 5% and the drug company pays 70%. If you are receiving "Extra Help" the coverage gap may not apply.

CATASTROPHIC COVERAGE

You enter catastrophic coverage when your true out-of-pocket costs reach $8,000. You pay $0.

NOTES

Multi-Language Insert – REQUIRED INFORMATION

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 800-378-5234 (TTY 800-947-3529). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 800-378-5234 (TTY 800-947-3529). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 800-378-5234 (TTY 800-947-3529)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 800-378-5234 (TTY 800-947-3529)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 800-378-5234 (TTY 800-947-3529). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 800-378-5234 (TTY 800-947-3529). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 800-378-5234 (TTY 800-947-3529) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 800-378-5234 (TTY 800-947-3529). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 800-378-5234 (TTY 800-947-3529) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 5234-378-800 (TTY 3529-947-800). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 800-378-5234 (TTY 800-947-3529) . سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 800-378-5234 (TTY 800-947-3529) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 800-378-5234 (TTY 800-947-3529). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 800-378-5234 (TTY 800-947-3529). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 800-378-5234 (TTY 800-947-3529). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 800-378-5234 (TTY 800-947-3529). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、800-378-5234 (TTY 800-947-3529) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Hmong: Peb muaj cov kev pab cuam kws txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog peb li kev noj qab hauv huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais kws txhais lus pab dawb, tsuas yog hu rau peb ntawm tus xov tooj 800-378-5234 (TTY 800-947-3529). Qee tus neeg uas hais Askiv/Yam Lus koj paub tuaj yeem pab tau rau koj. Qhov no yog kev pab dawb.

network health

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Network Health Cares is a PPO D-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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