



**We are  
Wisconsin.  
Just like you.**

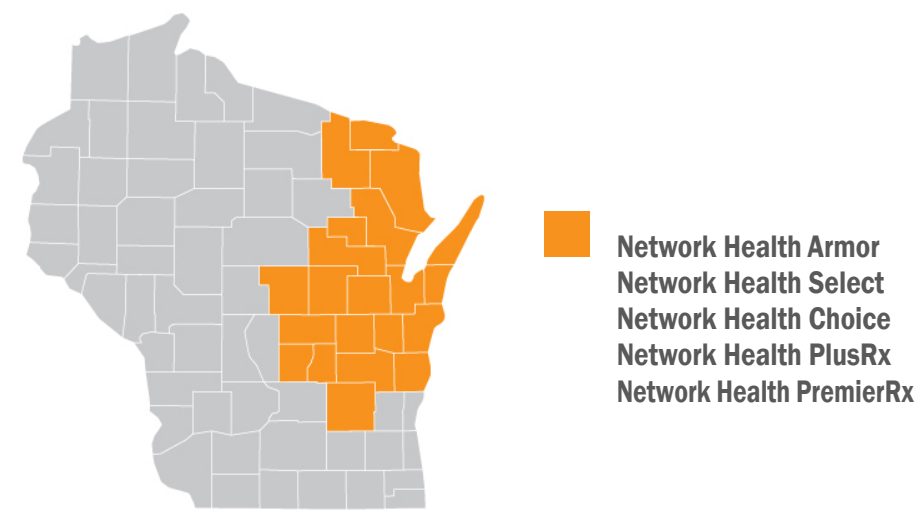
# **2026** Summary of Benefits Medicare Advantage PPO Plans **Northeast Wisconsin**

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

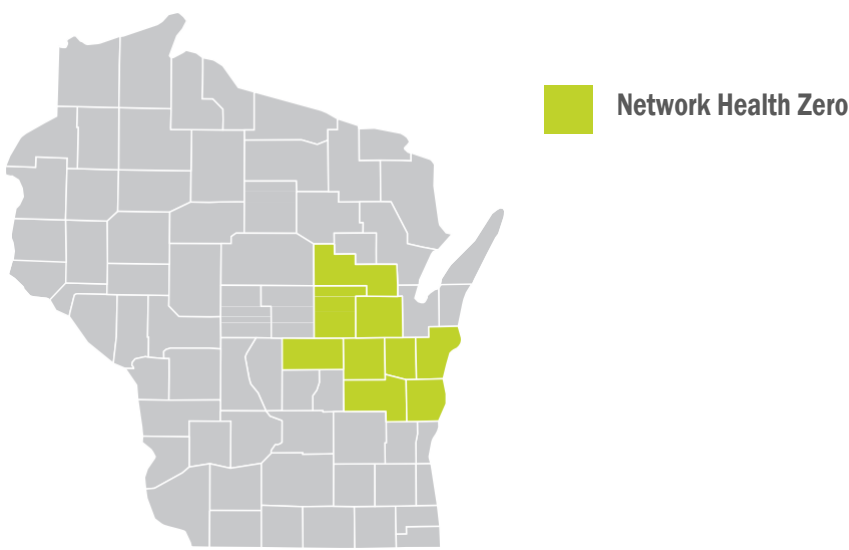
SERVICE AREA AND ELIGIBILITY

To be eligible to join the Network Health Northeast Wisconsin PPO plans described in this booklet, you must be enrolled in Medicare Part A and Part B and live in the service area.

This Summary of Benefits applies to the Network Health PPO plans and Northeast Wisconsin counties that are listed within each of the two map keys below.



Brown, Calumet, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Memominee, Oconto, Outagamie, Portage, Shawano, Sheboygan, Waupaca, Waushara, Winnebago



Calumet, Fond du Lac, Manitowoc, Outagamie, Shawano, Sheboygan, Waupaca, Waushara, Winnebago

SUMMARY OF BENEFITS

WHAT IS A SUMMARY OF BENEFITS?

This booklet gives you a summary of what we cover and what you pay on Network Health’s Northeast Wisconsin PPO plans. 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](https://networkhealth.com/medicare/plan-materials). Contact the member experience team for a printed copy.

WHAT IS A PREFERRED PROVIDER (PPO) PLAN?

A PPO plan allows you to **choose any doctor who accepts Medicare beneficiaries**. Doctors and other providers are divided into in-network or out-of-network, based on if they have a contract with Network Health. With a PPO plan, you can use both in- and out-of-network doctors. **With many Network Health Northeast Wisconsin PPO plans, you pay the same for in- and out-of-network providers.**

CONTACT NETWORK HEALTH

By Phone	Sales Team – <b>800-983-7587</b> Member Experience Team – <b>800-378-5234</b> TTY/TDD Users – <b>711</b>
Online	<b>networkhealth.com</b>
By Mail or In Person	<b>Network Health</b> <b>1570 Midway Pl.</b> <b>Menasha, WI 54952</b>
Hours of Operation	<ul style="list-style-type: none"><li>• Normal office hours are Monday–Friday, 8 a.m. to 5 p.m.</li><li>• 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.</li><li>• From October 1–March 31, you can call the sales team 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.</li></ul>
Additional Resources	<b>Medicare – Available 24 hours a day, seven days a week</b> For coverage and costs of Original Medicare, look in your current <i>“Medicare &amp; You”</i> handbook. View it online at <a href="https://www.medicare.gov">medicare.gov</a> 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.



2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health Armor (Excludes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Monthly Premium	\$0
Monthly Part B Premium Giveback <sup>2</sup> You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback	\$25 per month
Annual Medical Deductible	\$0
Annual Medical Maximum Out-of-Pocket	\$4,900 combined in- and out-of-network
Hospital Services	
Inpatient Hospital Services <sup>1</sup> Per admission	\$295 per day, days 1 - 6 \$0 days 7 and beyond
Outpatient Hospital Services <sup>1</sup>	\$275
Ambulatory Surgical Center <sup>1</sup>	\$225
General Services	
Primary Care Provider Visit	\$0
Specialist Visit	\$40
Preventive Care	
Preventive Care Visits*	\$0
Annual Medicare Wellness Visit	\$0
Annual Routine Physical	\$0
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	\$0
Medicare-Covered Vaccines Hepatitis B <sup>1</sup> , all other Part B	\$0
Emergency Care	
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	\$130
Urgent Care	
Urgent Care Visit Free-standing facility	\$40

\*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.

SUMMARY OF BENEFITS

Network Health Zero (Includes pharmacy)		Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
Please see county listing for service area.			
In-Network	Out-of-Network	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
\$0		\$0	\$0
\$2 per month		\$3.20 per month	\$24 per month
\$0		\$0	\$0
\$3,860	\$6,200 combined in- and out-of-network	\$3,900 combined in- and out-of-network	\$4,700 combined in- and out-of-network
Hospital Services			
\$340 per day, days 1 - 7 \$0 days 8 and beyond	\$700 per day, days 1 - 7 \$0 days 8 and beyond	\$275 per day, days 1 - 6 \$0 days 7 and beyond	\$315 per day, days 1 - 7 \$0 days 8 and beyond
\$300	\$600	\$300	\$300
\$250	\$500	\$250	\$200
General Services			
\$0	\$30	\$0	\$0
\$55	\$110	\$60	\$50
Preventive Care			
\$0	\$15	\$0	\$0
\$0	\$15	\$0	\$0
\$0	\$15	\$0	\$0
Virtual primary care and urgent care services cost the same as an in-person visit	Virtual primary care and urgent care services cost the same as an in-person visit	Virtual primary care and urgent care services cost the same as an in-person visit	Virtual primary care and urgent care services cost the same as an in-person visit
\$0	\$0	\$0	\$0
\$0	\$15	\$0	\$0
Emergency Care			
\$130	\$130	\$130	\$130
Urgent Care			
\$55	\$55	\$60	\$50

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](https://www.networkhealth.com/medicare/extra-benefits) for more information, this is not a medical benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs		Network Health Armor (Excludes pharmacy)	
		Please see county listing for service area.	
		YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
Diagnostic Services			
Diagnostic Tests <sup>1</sup> Such as ultrasound, EKG, stress test		\$40	
Labs What you pay may be based on the service received and/or where you are treated		\$0 or \$20	
Diagnostic Radiology Services <sup>1</sup> Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)		\$125	
X-rays		\$30	
Hearing Services			
Routine Hearing Exam <sup>2</sup>		\$0	
		\$40 out-of-network	
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues		\$40	
Hearing Aids <sup>2</sup> Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included		\$495 to \$1,695 per device in-network, must be purchased through TruHearing	No coverage out-of-network
Dental Services			
Dental Services <sup>2</sup> When receiving out-of-network care for eligible services, you must pay the difference between the Say Cheese Dental Network in-network payment and the amount charged by the out-of-network dentist		100% coverage in-network Includes one implant and resin \$5,000 combined in- and out-of-network annual maximum	
		Member pays 50% out-of-network	
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth		\$40	
Optional Comprehensive Dental Coverage <sup>2</sup>		Not available	
Vision Services			
Annual Routine Vision Exam <sup>2</sup>		\$0	
		\$40 reimbursement out-of-network	
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye		\$40	

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.

SUMMARY OF BENEFITS

Network Health Zero (Includes pharmacy)		Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
Please see county listing for service area.			
In-Network	Out-of-Network	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
Diagnostic Services			
\$30	\$60	\$40	\$90
\$0 or \$20	\$30 or \$40	\$0 or \$20	\$0 or \$40
\$300	\$600	\$300	\$295
\$30	\$60	\$40	\$90
Hearing Services			
\$0	\$40	\$0	\$0
		\$40 out-of-network	\$40 out-of-network
\$55	\$110	\$60	\$50
\$495 to \$1,695 per device in-network, must be purchased through TruHearing	No coverage out-of-network	\$495 to \$1,695 per device in-network, must be purchased through TruHearing No coverage out-of-network	\$495 to \$1,695 per device in-network, must be purchased through TruHearing No coverage out-of-network
Dental Services			
Up to \$625 reimbursed through Pick Your Perks		Up to \$550 reimbursed through Pick Your Perks	100% preventive, 50% comprehensive coverage in-network Includes one implant and resin \$1,500 combined in- and out-of-network annual maximum
			Member pays 80% out-of-network
\$55	\$110	\$60	\$50
\$49 monthly premium \$1,000 combined in- and out-of network annual maximum		\$49 monthly premium \$1,000 combined in- and out-of-network annual maximum	Not available
Vision Services			
\$10	\$40 reimbursement	\$10	\$0
		\$40 reimbursement out-of-network	\$40 reimbursement out-of-network
\$55	\$110	\$60	\$50

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health Armor (Excludes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
<b>Post-Cataract Eyewear</b> One pair of eyeglasses or contact lenses after each cataract surgery	\$0
<b>Additional Eyewear<sup>2</sup></b>	\$400 allowance at EyeMed providers
<b>Mental Health/Substance Abuse</b>	
<b>Outpatient Mental Health</b> Individual or group therapy	\$20
<b>Inpatient Mental Health<sup>1</sup></b> Per admission	\$395 per day, days 1 - 4 \$0 days 5 and beyond
<b>Opioid Treatment Services</b>	\$20
<b>Substance Abuse Services</b> Outpatient individual or group therapy	\$20
<b>Continued Care Services</b>	
<b>Skilled Nursing Facility<sup>1</sup></b> Per admission	\$0 per day, days 1 - 20 \$218 per day, days 21 - 45 \$0 days 46 - 100
<b>Outpatient Physical<sup>1</sup>, Occupational<sup>1</sup>, Speech Therapy</b>	\$30
<b>Transportation Services</b>	
<b>Air and Ground Ambulance Services</b>	\$300
<b>Non-Emergency Transportation<sup>3</sup></b> 24 one-way trips to get to and from dialysis for members diagnosed with ESRD	Covered
<b>Drug Coverage</b>	
<b>Medicare Part B Drugs<sup>1</sup></b> Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act	20% of the total cost
<b>Medicare Part D Drugs<sup>1</sup></b> See Your Drug Costs table for specific drug tier costs	Not covered
<b>Additional Benefits</b>	
<b>Pick Your Perks<sup>2</sup></b> Reimbursement for the following extra benefits: dental services, vision hardware, healthy home-delivered meals, non-emergency transportation, eligible over-the-counter items, acupuncture, massage therapy, personal training (4 visits or \$225 allowance), nutritional/dietary counseling	Not available

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.

<sup>3</sup>This is a Special Supplemental Benefit for the Chronically III (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

SUMMARY OF BENEFITS

Network Health Zero (Includes pharmacy)		Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
Please see county listing for service area.			
In-Network	Out-of-Network	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
\$0	\$0	\$0	\$0
Up to \$625 reimbursed through Pick Your Perks		Up to \$550 reimbursed through Pick Your Perks	\$200 allowance at EyeMed providers
Mental Health/Substance Abuse			
\$40	\$80	\$40	\$50
\$395 per day, days 1 - 4 \$0 days 5 and beyond	\$700 per day, days 1 - 7 \$0 days 8 and beyond	\$395 per day, days 1 - 4 \$0 days 5 and beyond	\$295 per day, days 1 - 4 \$0 days 5 and beyond
\$40	\$80	\$40	\$50
\$40	\$80	\$40	\$50
Continued Care Services			
\$0 per day, days 1 - 20 \$218 per day, days 21 – 45 \$0 days 46 - 100	\$0 per day, days 1 - 20 \$218 per day, days 21 – 45 \$0 days 46 - 100	\$0 per day, days 1 - 20 \$218 per day, days 21 – 45 \$0 days 46 - 100	\$0 per day, days 1 - 20 \$218 per day, days 21 – 45 \$0 days 46 - 100
\$55	\$110	\$55	\$50
Transportation Services			
\$300	\$300	\$300	\$275
In addition to 24 trips, up to \$625 reimbursed through Pick Your Perks for rides to medical appointments and pharmacies		In addition to 24 trips, up to \$550 reimbursed through Pick Your Perks for rides to medical appointments and pharmacies	Covered
Drug Coverage			
20% of the total cost	50% of the total cost	20% of the total cost	20% of the total cost
Covered	Not covered	Covered	Covered
Additional Benefits			
\$625		\$550	Not available

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit

<sup>3</sup>This is a Special Supplemental Benefit for the Chronically III (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health Armor (Excludes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Over-the-Counter Catalog <sup>2</sup>	\$100 per quarter Two orders per quarter No rollover on quarterly allowance
Fitness with One Pass™ <sup>2</sup>	Included
MDLIVE® Virtual Visit <sup>2</sup> For medical services	\$0
Travel Coverage	
Travel within the United States	Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.
International Emergency Coverage View the Evidence of Coverage at networkhealth.com/medicare/plan-materials for details	\$130 per incident \$100,000 Maximum benefit
Recovery and Rehabilitation Services	
Durable Medical Equipment Such as traditional insulin pumps <sup>1</sup> , CPAP machines, prosthetic devices <sup>1</sup> , etc.	20% of the allowed amount
Durable Medical Equipment for Home Infusion	0% of the allowed amount
Medicare-Covered Chiropractic Services Manipulation of the spine to correct misalignment of one or more of the bones of your spine	\$15
Medicare-Covered Acupuncture For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	\$40
Medicare-Covered Home Health Care Visits <sup>1</sup>	\$0
Cancer Services	
Chemotherapy <sup>1</sup>	20% of the allowed amount
Radiation Therapy <sup>1</sup> Per service	20% of the allowed amount
Acupuncture <sup>3</sup> Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting	\$0

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.  
<sup>3</sup>This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

SUMMARY OF BENEFITS

Network Health Zero (Includes pharmacy)		Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
Please see county listing for service area.			
In-Network	Out-of-Network	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
Up to \$625 reimbursed through Pick Your Perks		Up to \$550 reimbursed through Pick Your Perks	\$40 per quarter Two orders per quarter No rollover on quarterly allowance
Included		Included	Included
\$0	Not Covered	\$0	\$0
Travel Coverage			
Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.		Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.	Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.
\$130 per incident \$100,000 Maximum benefit	\$130 per incident \$100,000 Maximum benefit	\$130 per incident \$100,000 Maximum benefit	\$130 per incident \$100,000 Maximum benefit
Recovery and Rehabilitation Services			
20% of the allowed amount	25% of the allowed amount	20% of the allowed amount	20% of the allowed amount
0% of the allowed amount	25% of the allowed amount	0% of the allowed amount	0% of the allowed amount
\$20	\$40	\$20	\$15
\$55	\$110	\$60	\$50
\$0	\$0	\$0	\$0
Cancer Services			
20% of the allowed amount	50% of the allowed amount	20% of the allowed amount	20% of the allowed amount
20% of the allowed amount	20% of the allowed amount	20% of the allowed amount	20% of the allowed amount
\$0	\$0	\$0	\$0

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.  
<sup>3</sup>This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health Armor (Excludes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Diabetic Services	
<b>Diabetes Monitoring Supplies and Test Strips</b> Preferred test strips Preferred continuous glucose monitoring devices and supplies <sup>1</sup> obtained through your pharmacy Must have a diabetic diagnosis with insulin use All other brands are not covered	\$0 for up to a 90-day supply
<b>Diabetic Shoe Inserts</b> Copayment per pair	\$10
<b>Diabetes Management</b> Diabetes self-management training teaches you to cope with and manage your diabetes	\$0
<b>Part B Insulin<sup>1</sup></b> One-month supply	20% of the total cost, up to \$35
Renal Services	
<b>Dialysis</b> Per treatment	20% of the allowed amount

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.

SUMMARY OF BENEFITS

Network Health Zero (Includes pharmacy)		Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
Please see county listing for service area.			
In-Network	Out-of-Network	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
Diabetic Services			
\$0 for up to a 90-day supply	\$0 for up to a 90-day supply	\$0 for up to a 90-day supply	\$0 for up to a 90-day supply
\$10	\$30	\$10	\$10
\$0	\$0	\$0	\$0
20% of the total cost, up to \$35	50% of the total cost	20% of the total cost, up to \$35	20% of the total cost, up to \$35
Renal Services			
20% of the allowed amount		20% of the allowed amount	20% of the allowed amount

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.



## 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Drug Costs		Network Health Zero (Includes pharmacy)	Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
		Please see county listing for service area.		
<b>Yearly Drug Deductible</b> You pay the full amount of your covered Part D drugs until the deductible is met.		\$330 Applies to Tiers 2 - 5	\$330 Applies to Tiers 2 - 5	\$300 Applies to Tiers 2 - 5
<b>INITIAL COVERAGE – Amount shown is the maximum you will pay. You may pay less.</b>				
PREFERRED	<b>30-Day Supply</b> <b>Preferred Pharmacy or Preferred Mail Order Pharmacy</b>	\$0 for Tier 1 \$8 for Tier 2 23% for Tier 3 25% for Tier 4 29% for Tier 5	\$1 for Tier 1 \$8 for Tier 2 21% for Tier 3 29% for Tier 4 29% for Tier 5	\$1 for Tier 1 \$8 for Tier 2 23% for Tier 3 28% for Tier 4 29% for Tier 5
	<b>3-Month Supply</b> <b>Preferred Pharmacy</b> <b>100-Day Supply for Tier 1</b> <b>90-Day Supply for Tiers 2-4</b>	\$0 for Tier 1 \$20 for Tier 2 23% for Tier 3 25% for Tier 4 Tier 5 is not available	\$2 for Tier 1 \$20 for Tier 2 21% for Tier 3 29% for Tier 4 Tier 5 is not available	\$2 for Tier 1 \$20 for Tier 2 23% for Tier 3 28% for Tier 4 Tier 5 is not available
	<b>3-Month Supply</b> <b>Preferred Mail Order Pharmacy</b> <b>100-Day Supply for Tier 1</b> <b>90-Day Supply for Tiers 2-4</b>	\$0 for Tier 1 \$0 for Tier 2 after deductible 23% for Tier 3 25% for Tier 4 Tier 5 is not available	\$0 for Tier 1 \$0 for Tier 2 after deductible 21% for Tier 3 29% for Tier 4 Tier 5 is not available	\$0 for Tier 1 \$0 for Tier 2 after deductible 23% for Tier 3 28% for Tier 4 Tier 5 is not available
STANDARD	<b>30-Day Supply</b> <b>Standard Pharmacy or Standard Mail Order Pharmacy</b>	\$8 for Tier 1 \$17 for Tier 2 25% for Tier 3 25% for Tier 4 29% for Tier 5	\$8 for Tier 1 \$17 for Tier 2 25% for Tier 3 29% for Tier 4 29% for Tier 5	\$8 for Tier 1 \$17 for Tier 2 25% for Tier 3 28% for Tier 4 29% for Tier 5
	<b>3-Month Supply</b> <b>Standard Pharmacy or Standard Mail Order Pharmacy</b> <b>100-Day Supply for Tier 1</b> <b>90-Day Supply for Tiers 2-4</b>	\$20 for Tier 1 \$42 for Tier 2 25% for Tier 3 25% for Tier 4 Tier 5 is not available	\$20 for Tier 1 \$42 for Tier 2 25% for Tier 3 29% for Tier 4 Tier 5 is not available	\$20 for Tier 1 \$42 for Tier 2 25% for Tier 3 28% for Tier 4 Tier 5 is not available
<b>Part D Insulin and Vaccines</b>				
<b>Part D Insulin<sup>1</sup></b> One-month supply		Lesser of 25% or \$35	Lesser of 25% or \$35	Lesser of 25% or \$35
<b>Part D Vaccines</b> Shingrix, RSV, all other adult ACIP recommended vaccines		\$0	\$0	\$0
<b>CATASTROPHIC COVERAGE</b>				
You enter catastrophic coverage when your total out-of-pocket costs reach \$2,100. You pay \$0.				

<sup>1</sup>Service may require prior authorization.

## NOTES

[illegible]



2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)	
Your Costs	Network Health PlusRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Monthly Premium	\$73
Monthly Part B Premium Giveback <sup>2</sup> You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback	Not included
Annual Medical Deductible	\$0
Annual Medical Maximum Out-of-Pocket	\$3,400 combined in- and out-of-network
Hospital Services	
Inpatient Hospital Services <sup>1</sup> Per admission	\$175 per day, days 1 - 5 \$0 days 6 and beyond
Outpatient Hospital Services <sup>1</sup>	\$350
Ambulatory Surgical Center <sup>1</sup>	\$350
General Services	
Primary Care Provider Visit	\$15
Specialist Visit	\$40
Preventive Care	
Preventive Care Visits*	\$0
Annual Medicare Wellness Visit	\$0
Annual Routine Physical	\$0
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	\$0
Medicare-Covered Vaccines Hepatitis B <sup>1</sup> , all other Part B	\$0
Emergency Care	
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	\$130
Urgent Care	
Urgent Care Visit Free-standing facility	\$40
Diagnostic Services	
Diagnostic Tests <sup>1</sup> Such as ultrasound, EKG, stress test	\$25

\*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.

SUMMARY OF BENEFITS	
Your Costs	Network Health PremierRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Monthly Premium	\$226
Monthly Part B Premium Giveback <sup>2</sup> You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback	Not included
Annual Medical Deductible	\$0
Annual Maximum Out-of-Pocket (Does not include Part D prescription drugs)	\$3,400 combined in- and out-of-network
Hospital Services	
Inpatient Hospital Services <sup>1</sup> Per admission	\$75 per day, days 1 - 5 \$0 days 6 and beyond
Outpatient Hospital Services <sup>1</sup>	\$0
Ambulatory Surgical Center <sup>1</sup>	\$0
General Services	
Primary Care Provider Visit	\$10
Specialist Visit	\$20
Preventive Care	
Preventive Care Visits*	\$0
Annual Medicare Wellness Visit	\$0
Annual Routine Physical	\$0
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	\$0
Medicare-Covered Vaccines Hepatitis B <sup>1</sup> , all other Part B	\$0
Emergency Care	
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	\$130
Urgent Care	
Urgent Care Visit Free-standing facility	\$20
Diagnostic Services	
Diagnostic Tests <sup>1</sup> Such as ultrasound, EKG, stress test	\$0

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](https://networkhealth.com/medicare/extra-benefits) for more information, this is not a medical benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)	
Your Costs	Network Health PlusRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
<b>Labs</b> What you pay may be based on the service received and/or where you are treated	\$0 or \$5
<b>Diagnostic Radiology Services<sup>1</sup></b> Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	\$100
<b>X-rays</b>	\$25
Hearing Services	
<b>Routine Hearing Exam<sup>2</sup></b>	\$0
	\$40 out-of-network
<b>Diagnostic Hearing Exam</b> Exam to diagnose and treat hearing issues	\$25
<b>Hearing Aids<sup>2</sup></b> Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included	\$495 to \$1,695 per device in-network, must be purchased through TruHearing No coverage out-of-network
Dental Services	
<b>Dental Services<sup>2</sup></b> When receiving out-of-network care for eligible services, you must pay the difference between the Say Cheese Dental Network in-network payment and the amount charged by the out-of-network dentist	100% preventive, 50% comprehensive coverage in-network. Member pays 80% out-of-network \$750 combined in- and out-of-network annual maximum
<b>Medicare-Covered Dental Services</b> Does not include services in connection with care, treatment, filling, removal or replacement of teeth	\$25
<b>Optional Comprehensive Dental Coverage<sup>2</sup></b>	\$49 monthly premium \$1,000 combined in- and out-of-network annual maximum
Vision Services	
<b>Annual Routine Vision Exam<sup>2</sup></b>	\$10
	\$40 reimbursement out-of-network
<b>Diagnostic Eye Exam</b> To diagnose and treat diseases and conditions of the eye	\$25
<b>Post-Cataract Eyewear</b> One pair of eyeglasses or contact lenses after each cataract surgery	\$0
<b>Additional Eyewear<sup>2</sup></b> At EyeMed providers	Not covered
Mental Health/Substance Abuse	
<b>Outpatient Mental Health</b> Individual or group therapy	\$35
<b>Inpatient Mental Health<sup>1</sup></b> Per admission	\$150 per day, days 1 - 10 \$0 days 11 and beyond

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](https://www.networkhealth.com/medicare/extra-benefits) for more information, this is not a medical benefit.

SUMMARY OF BENEFITS	
Your Costs	Network Health PremierRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
<b>Labs</b> What you pay may be based on the service received and/or where you are treated	\$0
<b>Diagnostic Radiology Services<sup>1</sup></b> Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	\$0
<b>X-rays</b>	\$0
Hearing Services	
<b>Routine Hearing Exam<sup>2</sup></b>	\$0
	\$40 out-of-network
<b>Diagnostic Hearing Exam</b> Exam to diagnose and treat hearing issues	\$0
<b>Hearing Aids<sup>2</sup></b> Maximum of two hearing aids per year Hearing aid evaluation with TruHearing, fitting included	\$495 to \$1,695 per device in-network, must be purchased through TruHearing No coverage out-of-network
Dental Services	
<b>Dental Services<sup>2</sup></b> When receiving out-of-network care for eligible services, you must pay the difference between the Say Cheese Dental Network in-network payment and the amount charged by the out-of-network dentist	Preventive: 1 cleaning and exam per year for \$30 \$100 reimbursement out-of-network
<b>Medicare-Covered Dental Services</b> Does not include services in connection with care, treatment, filling, removal or replacement of teeth	\$0
<b>Optional Comprehensive Dental Coverage<sup>2</sup></b>	\$49 monthly premium \$1,000 combined in- and out-of-network annual maximum
Vision Services	
<b>Annual Routine Vision Exam<sup>2</sup></b>	\$10
	\$40 reimbursement out-of-network
<b>Diagnostic Eye Exam</b> To diagnose and treat diseases and conditions of the eye	\$0
<b>Post-Cataract Eyewear</b> One pair of eyeglasses or contact lenses after each cataract surgery	\$0
<b>Additional Eyewear<sup>2</sup></b> At EyeMed providers	Not covered
Mental Health/Substance Abuse	
<b>Outpatient Mental Health</b> Individual or group therapy	\$0
<b>Inpatient Mental Health<sup>1</sup></b> Per admission	\$0

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](https://www.networkhealth.com/medicare/extra-benefits) for more information, this is not a medical benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health PlusRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Opioid Treatment Services	\$35
Substance Abuse Services Outpatient individual or group therapy	\$20
Continued Care Services	
Skilled Nursing Facility <sup>1</sup> Per admission	\$20 per day, days 1 - 20 \$218 per day, days 21 – 40 \$0 days 41 - 100
Outpatient Physical <sup>1</sup> , Occupational <sup>1</sup> , Speech Therapy	\$40
Transportation Services	
Air and Ground Ambulance Services	\$250
Non-Emergency Transportation <sup>3</sup> 24 one-way trips to get to and from dialysis for members diagnosed with ESRD	Covered
Drug Coverage	
Medicare Part B Drugs <sup>1</sup> Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act	20% of the total cost
Medicare Part D Drugs <sup>1</sup> See Your Drug Costs table for specific drug tier costs	Covered
Additional Benefits	
Pick Your Perks <sup>2</sup> Reimbursement for the following extra benefits: dental services, vision hardware, healthy home-delivered meals, non-emergency transportation, eligible over-the-counter items, acupuncture, massage therapy, personal training (4 visits or \$225 allowance), nutritional/dietary counseling	Not available
Over-the-Counter Catalog <sup>2</sup>	\$140 per quarter Two orders per quarter No rollover on quarterly allowance
Fitness with One Pass™ <sup>2</sup>	Included
MDLIVE® Virtual Visit <sup>2</sup> For medical services	\$0
Travel Coverage	
Travel within the United States	Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.

<sup>3</sup>This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

SUMMARY OF BENEFITS

Your Costs	Network Health PremierRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Opioid Treatment Services	\$0
Substance Abuse Services Outpatient individual or group therapy	\$0
Continued Care Services	
Skilled Nursing Facility <sup>1</sup> Per admission	\$0
Outpatient Physical <sup>1</sup> , Occupational <sup>1</sup> , Speech Therapy	\$20
Transportation Services	
Air and Ground Ambulance Services	\$0
Non-Emergency Transportation <sup>3</sup> 24 one-way trips to get to and from dialysis for members diagnosed with ESRD	Covered
Drug Coverage	
Medicare Part B Drugs <sup>1</sup> Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act	20% of the total cost
Medicare Part D Drugs <sup>1</sup> See Your Drug Costs table for specific drug tier costs	Covered
Additional Benefits	
Pick Your Perks <sup>2</sup> Reimbursement for the following extra benefits: dental services, vision hardware, healthy home-delivered meals, non-emergency transportation, eligible over-the-counter items, acupuncture, massage therapy, personal training (4 visits or \$225 allowance), nutritional/dietary counseling	Not available
Over-the-Counter Catalog <sup>2</sup>	\$85 per quarter Two orders per quarter No rollover on quarterly allowance
Fitness with One Pass™ <sup>2</sup>	Included
MDLIVE® Virtual Visit <sup>2</sup> For medical services	\$0
Travel Coverage	
Travel within the United States	Receive in-network coverage when you venture outside Wisconsin and within the United States territories. You can see any provider who accepts Medicare beneficiaries.

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/extra-benefits](#) for more information, this is not a medical benefit.

<sup>3</sup>This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health PlusRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Recovery and Rehabilitation Services	
<b>International Emergency Coverage–</b> View the Evidence of Coverage at networkhealth.com/ medicare/plan-materials for details	\$130 per incident \$100,000 Maximum benefit
<b>Durable Medical Equipment</b> Such as traditional insulin pumps <sup>1</sup> , CPAP machines, prosthetic devices <sup>1</sup> , etc.	20% of the allowed amount
<b>Durable Medical Equipment for Home Infusion</b>	0% of the allowed amount
<b>Medicare-Covered Chiropractic Services</b> Manipulation of the spine to correct misalignment of one or more of the bones of your spine	\$20
<b>Medicare-Covered Acupuncture</b> For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	\$40
<b>Medicare-Covered Home Health Care Visits<sup>1</sup></b>	\$0
Cancer Services	
<b>Chemotherapy<sup>1</sup></b>	20% of the allowed amount
<b>Radiation Therapy<sup>1</sup></b> Per service	\$60
<b>Acupuncture<sup>3</sup></b> Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting	\$0
Diabetic Services	
<b>Diabetes Monitoring Supplies and Test Strips</b> Preferred test strips Preferred continuous glucose monitoring devices and supplies <sup>1</sup> obtained through your pharmacy Must have a diabetic diagnosis with insulin use All other brands are not covered	\$0 for up to a 90-day supply
<b>Diabetic Shoe Inserts</b> Copayment per pair	\$10
<b>Diabetes Management</b> Diabetes self-management training teaches you to cope with and manage your diabetes	\$0
<b>Part B Insulin<sup>1</sup></b> One-month supply	20% of the total cost, up to \$35
Renal Services	
<b>Dialysis</b> Per treatment	20% of the allowed amount

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.  
<sup>3</sup>This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.

SUMMARY OF BENEFITS

Your Costs	Network Health PremierRx (Includes pharmacy)
	Please see county listing for service area.
	YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS
Recovery and Rehabilitation Services	
<b>International Emergency Coverage</b> View the Evidence of Coverage at networkhealth.com/ medicare/plan-materials for details	\$130 per incident \$100,000 Maximum benefit
<b>Durable Medical Equipment</b> Such as traditional insulin pumps <sup>1</sup> , CPAP machines, prosthetic devices <sup>1</sup> , etc.	\$0
<b>Durable Medical Equipment for Home Infusion</b>	\$0
<b>Medicare-Covered Chiropractic Services</b> Manipulation of the spine to correct misalignment of one or more of the bones of your spine	\$20
<b>Medicare-Covered Acupuncture</b> For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	\$20
<b>Medicare-Covered Home Health Care Visits<sup>1</sup></b>	\$0
Cancer Services	
<b>Chemotherapy<sup>1</sup></b>	20% of the allowed amount
<b>Radiation Therapy<sup>1</sup></b> Per service	\$0
<b>Acupuncture<sup>3</sup></b> Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting	\$0
Diabetic Services	
<b>Diabetes Monitoring Supplies and Test Strips</b> Preferred test strips Preferred continuous glucose monitoring devices and supplies <sup>1</sup> obtained through your pharmacy Must have a diabetic diagnosis with insulin use All other brands are not covered	\$0 for up to a 90-day supply
<b>Diabetic Shoe Inserts</b> Copayment per pair	\$0
<b>Diabetes Management</b> Diabetes self-management training teaches you to cope with and manage your diabetes	\$0
<b>Part B Insulin<sup>1</sup></b> One-month supply	20% of the total cost, up to \$35
Renal Services	
<b>Dialysis</b> Per treatment	20% of the allowed amount

<sup>1</sup>Service may require prior authorization.  
<sup>2</sup>Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.  
<sup>3</sup>This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.



2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Drug Costs		Network Health PlusRx (Includes pharmacy)	Network Health PremierRx (Includes pharmacy)
		Please see county listing for service area.	
Yearly Drug Deductible You pay the full amount of your covered Part D drugs until the deductible is met		\$340 Applies to Tiers 2 - 5	\$340 Applies to Tiers 2 - 5
INITIAL COVERAGE – Amount shown is the maximum you will pay. You may pay less.			
PREFERRED	30-Day Supply Preferred Pharmacy or Preferred Mail Order Pharmacy	\$0 for Tier 1 \$8 for Tier 2 23% for Tier 3 25% for Tier 4 29% for Tier 5	\$0 for Tier 1 \$8 for Tier 2 23% for Tier 3 25% for Tier 4 29% for Tier 5
	3-Month Supply Preferred Pharmacy 100-Day Supply for Tier 1 90-Day Supply for Tiers 2-4	\$0 for Tier 1 \$20 for Tier 2 23% for Tier 3 25% for Tier 4 Tier 5 is not available	\$0 for Tier 1 \$20 for Tier 2 23% for Tier 3 25% for Tier 4 Tier 5 is not available
	3-Month Supply Preferred Mail Order Pharmacy 100-Day Supply for Tier 1 90-Day Supply for Tiers 2-4	\$0 for Tier 1 \$0 for Tier 2 after deductible 23% for Tier 3 25% for Tier 4 Tier 5 is not available	\$0 for Tier 1 \$0 for Tier 2 after deductible 23% for Tier 3 25% for Tier 4 Tier 5 is not available
STANDARD	30-Day Supply Standard Pharmacy or Standard Mail Order Pharmacy	\$8 for Tier 1 \$17 for Tier 2 25% for Tier 3 25% for Tier 4 29% for Tier 5	\$8 for Tier 1 \$17 for Tier 2 25% for Tier 3 25% for Tier 4 29% for Tier 5
	3-Month Supply Standard Pharmacy or Standard Mail Order Pharmacy 100-Day Supply for Tier 1 90-Day Supply for Tiers 2-4	\$20 for Tier 1 \$42 for Tier 2 25% for Tier 3 25% for Tier 4 Tier 5 is not available	\$20 for Tier 1 \$42 for Tier 2 25% for Tier 3 25% for Tier 4 Tier 5 is not available
Part D Insulin and Vaccines			
Part D Insulin <sup>1</sup> One-month supply		Lesser of 25% or \$35	Lesser of 25% or \$35
Part D Vaccines Shingrix, RSV, all other adult ACIP recommended vaccines		\$0	\$0
CATASTROPHIC COVERAGE			
You enter catastrophic coverage when your total out-of-pocket costs reach \$2,100. You pay \$0.			

<sup>1</sup>Service may require prior authorization.

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a member of the member experience team at **800-378-5234** (TTY 711), Monday–Friday from 8 a.m. to 8 p.m. From October 1–March 31, we’re available every day from 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **networkhealth.com/medicare/plan-materials** or call **800-378-5234** (TTY 711) 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.
- ☐ Review the formulary to make sure your drugs are covered.
- ☐ Review how enrolling into a Network Health Medicare Advantage plan will impact your current healthcare coverage.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you may pay a higher copayment for services received by non-contracted providers. Network Health Zero plan has copayment differences when you see in- or out-of-network providers. All other plans have the same copayment amounts for the services received in- and out-of-network.

**Discrimination is Against the Law**

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Network Health does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - o Qualified interpreters
  - o Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Network Health’s Compliance Officer.

If you believe that Network Health 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:

Network Health  
Attn: Compliance Officer  
1570 Midway Place  
Menasha, WI 54952  
Phone: 800-378-5234  
(TTY users should call 711)  
Email: [compliance@networkhealth.com](mailto:compliance@networkhealth.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health’s compliance Officer 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  
1-800-368-1019, 800-537-7697 (TDD)

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

This notice is available at Network Health’s website: [networkhealth.com](http://networkhealth.com)

**Notice of Availability of Language Assistance Services and Auxiliary Aids and Services**

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-378-5234 (TTY: 711) or speak to your provider.

**Albanian:** Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shpresë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 800-378-5234 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

**Arabic:** إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات تنبيه كما تتوفر وسائل مساعدة وخدمات المساعدة اللغوية المجانية. مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. أو 5234-378-800 (711) اتصل على الرقم. تحدث إلى مقدم الخدمة.

**Chinese:** 如果您说中文，我们将免费为您提供提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-378-5234（文本电话：711）或咨询您的服务提供商。

**French:** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 800-378-5234 (TTY : 711) ou parlez à votre fournisseur.

**German:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-378-5234 (TTY : 711) an oder sprechen Sie mit Ihrem Provider.

**Hindi:** यदि आप हिंदी बोलते हैं, तो आपके लिए निः शु भाषा सहायता सेवाएं उपलब्धी हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निः श उपलब्धी 800-378-5234 (TTY : 711) पर कॉल करेया अपने प्रदाता से बात करें ।

**Hmong:** Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 800-378-5234 (TTY : 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

**Korean:** 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조기구 및 서비스도 무료로 제공됩니다. 800-378-5234 (TTY : 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

**Laotian:** ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ800-378-5234(TTY : 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

**Pennsylvania Dutch:** Wann du Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 800-378-5234 (TTY: 711) uff odder schwetz mit dei Provider.

**Polish:** Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 800-378-5234(TTY : 711) lub porozmawiaj ze swoim dostawcą.

**Russian:** Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 800-378-5234 (TTY : 711) или обратитесь к своему поставщику услуг.

**Spanish:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-378-5234 (TTY : 711) o hable con su proveedor.Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-378-5234 (TTY : 711) o makipag-usap sa iyong provider.

**Vietnamese:** Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-378-5234 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.





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Network Health Medicare Advantage Plans include PPO plans with a Medicare contract. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal. 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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