

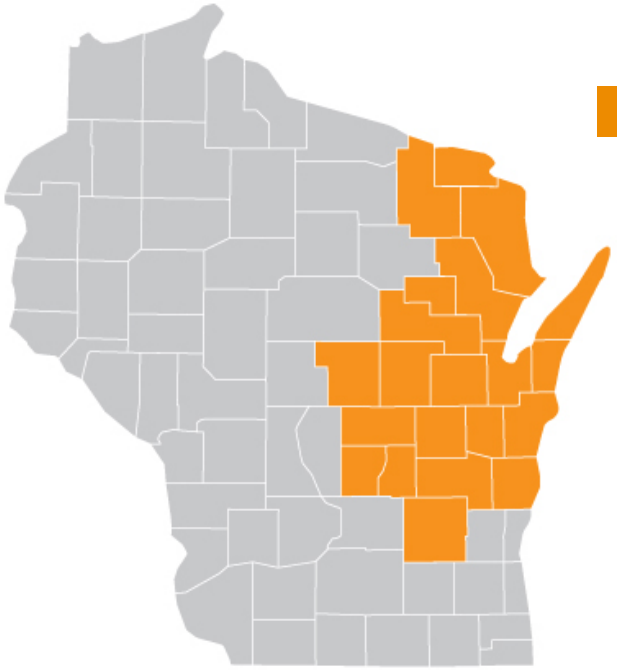
2027 Summary of Benefits
Medicare Advantage PPO Plans
Northeast Wisconsin

2027 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.



Network Health Armor
Network Health Select
Network Health Choice
Network Health PlusRx
Network Health PremierRx

Brown, Calumet, Dodge, Door, Florence, Fond du Lac, Forest, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Menominee, Oconto, Outagamie, Portage, 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**. 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.

CONTACT NETWORK HEALTH

By Phone	Sales Team – **800-983-7587** Member Experience Team – **800-378-5234** TTY/TDD Users – **711**
Online	**networkhealth.com**
By Mail or In Person	**Network Health** **1570 Midway Pl.** **Menasha, WI 54952** **Network Health** **16960 W. Greenfield Ave., Suite 5** **Brookfield, WI 53005**
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 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.
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.

[1]Service may require prior authorization.
[2]Visit **networkhealth.com/medicare/extra-benefits** for more information, this is not a medical benefit.
[3]Deductible applies first in certain situations, then you pay the same in- and out-of-network.

2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

SUMMARY OF BENEFITS

Your Costs	Network Health Select (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	Network Health Choice (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	Network Health Armor (Excludes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Monthly Premium	$0	$0	$0
Monthly Part B Premium Giveback[2] You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback	Not included	Not included	$55 per month
Annual Medical Deductible	$200	$500	$0
Annual Medical Maximum Out-of-Pocket	$4,450 combined in- and out-of-network	$5,100 combined in- and out-of-network	$4,900 combined in- and out-of-network
Hospital Services			
Inpatient Hospital Services[1] *Deductible applies*	$340 per day, days 1 - 6 $0 days 7 and beyond	$340 per day, days 1 - 7 $0 days 8 and beyond	$295 per day, days 1 - 6 $0 days 7 and beyond
Outpatient Hospital Services[1] *Deductible applies*	$300	$300	$275
Ambulatory Surgical Center[1] *Deductible applies out-of-network*	$250	$200	$225
General Services			
Primary Care Provider Visit *Deductible applies out-of-network*	$0	$0	$0
Specialist Visit *Deductible applies out-of-network*	$60	$50	$40
Preventive Care			
Preventive Care Visits	$0	$0	$0
Annual Medicare Wellness Visit	$0	$0	$0
Annual Routine Physical	$0	$0	$0
Physician Telehealth Services *Deductible applies out-of-network*	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
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	$0	$0	$0
Medicare-Covered Vaccines Hepatitis B[1], all other Part B	$0	$0	$0
Emergency Care			
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	$130	$130	$130
Urgent Care			
Urgent Care Visit Free-standing facility	$60	$50	$40

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2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health Select (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
Diagnostic Services		
Diagnostic Tests[1] Such as ultrasound, EKG, stress test *Deductible applies*	$40	
Labs What you pay may be based on the service received and/or where you are treated *Deductible applies out-of-network*	$0 or $20	
Diagnostic Radiology Services[1] Advanced imaging (PET, CAT, MRI, MRA, NUC Scans) *Deductible applies*	$300	
X-rays *Deductible applies*	$40	
Hearing Services		
Routine Hearing Exam[2]	$0 in-network	$200 deductible, then 90% of the allowed amount out-of-network
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues *Deductible applies out-of-network*	$60	
Hearing Aids[2] Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device in-network	$4,000 deductible then 90% of the allowed amount per pair of hearing aids out-of-network. Reimbursement up to a maximum of $75
Dental Services		
Dental Services[2] 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	Up to $400 reimbursed through Pick Your Perks	

SUMMARY OF BENEFITS

Your Costs	Network Health Choice (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]		Network Health Armor (Excludes pharmacy)	
Diagnostic Services				
Diagnostic Tests[1] Such as ultrasound, EKG, stress test *Deductible applies*	$90		$40	
Labs What you pay may be based on the service received and/or where you are treated *Deductible applies out-of-network*	$0 or $40		$0 or $20	
Diagnostic Radiology Services[1] Advanced imaging (PET, CAT, MRI, MRA, NUC Scans) *Deductible applies*	$295		$125	
X-rays *Deductible applies*	$90		$30	
Hearing Services				
Routine Hearing Exam[2]	$0 in-network	$200 deductible, then 90% of the allowed amount out-of-network	$0 in-network	$200 deductible, then 90% of the allowed amount out-of-network
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues *Deductible applies out-of-network*	$50		$40	
Hearing Aids[2] Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device in-network	$4,000 deductible then 90% of the allowed amount per pair of hearing aids out-of-network. Reimbursement up to a maximum of $75	$495 to $1,695 per device in-network	$4,000 deductible then 90% of the allowed amount per pair of hearing aids out-of-network. Reimbursement up to a maximum of $75
Dental Services				
Dental Services[2] 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% of the allowed amount comprehensive coverage in-network	Member pays 80% of the allowed amount out-of-network	100% of the allowed amount in-network	Member pays 50% of the allowed amount out-of-network
	$1,000 combined in- and out-of-network annual maximum		$3,500 combined in- and out-of-network annual maximum	

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SUMMARY OF BENEFITS

Your Costs	Network Health Select (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]		Network Health Choice (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]		Network Health Armor (Excludes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth *Deductible applies out-of-network*	$60		$50		$40	
Optional Comprehensive Dental Coverage[2]	$39 monthly premium $1,000 combined in- and out-of-network annual maximum		Not available		Not available	
Vision Services						
Annual Routine Vision Exam[2]	$10 in-network	$40 reimbursement out-of-network	$10 in-network	$40 reimbursement out-of-network	$0 in-network	$40 reimbursement out-of-network
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye *Deductible applies out-of-network*	$60		$50		$40	
Post-Cataract Eyewear One pair of eyeglasses or contact lenses after each cataract surgery *Deductible applies out-of-network*	$0		$0		$0	
Additional Eyewear[2]	Up to $400 reimbursed through Pick Your Perks		Not covered		$400 allowance in-network, or	$400 reimbursement out-of-network
Mental Health/Substance Abuse						
Outpatient Mental Health Individual or group therapy *Deductible applies out-of-network*	$40		$50		$20	
Inpatient Mental Health[1] *Deductible applies*	$395 per day, days 1 - 4 $0 days 5 and beyond		$295 per day, days 1 - 4 $0 days 5 and beyond		$395 per day, days 1 - 4 $0 days 5 and beyond	
Opioid Treatment Services *Deductible applies out-of-network*	$40		$50		$20	
Substance Abuse Services Outpatient individual or group therapy *Deductible applies out-of-network*	$40		$50		$20	
Continued Care Services						
Skilled Nursing Facility[1] *Deductible applies*	$0 per day, days 1 - 20 $221 per day, days 21 – 45 $0 days 46 - 100		$0 per day, days 1 - 20 $221 per day, days 21 – 45 $0 days 46 - 100		$0 per day, days 1 - 20 $221 per day, days 21 – 45 $0 days 46 - 100	
Outpatient Physical[1], Occupational[1], Speech Therapy *Deductible applies*	$55		$50		$30	
Transportation Services						
Air and Ground Ambulance Services *Deductible applies out-of-network*	$300		$275		$300	

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Your Costs	Network Health Select (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
Drug Coverage		
Medicare Part B Drugs[1] *Deductible applies*	20% of the total cost	
Medicare Part D Drugs[1] See Your Drug Costs table for specific drug tier costs	Covered at in-network pharmacies only	
Additional Benefits		
Pick Your Perks[2] Reimbursement for the following extra benefits: dental services, vision hardware, non-emergency transportation, eligible over-the-counter items, acupuncture, massage therapy, personal training (4 visits or $225 allowance), nutritional/dietary counseling	$400	
Over-the-Counter (OTC) Catalog[2]	Not available	
Fitness with One Pass™ [2]	$0 in-network	Up to $10 reimbursement annually out-of-network
MD Live® Virtual Visit[2] 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	$130 per incident $100,000 Maximum benefit	

SUMMARY OF BENEFITS

Your Costs	Network Health Choice (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]		Network Health Armor (Excludes pharmacy)	
Drug Coverage				
Medicare Part B Drugs[1] *Deductible applies*	20% of the total cost		20% of the total cost	
Medicare Part D Drugs[1] See Your Drug Costs table for specific drug tier costs	Covered at in-network pharmacies only		Not covered	
Additional Benefits				
Pick Your Perks[2] Reimbursement for the following extra benefits: dental services, vision hardware, non-emergency transportation, eligible over-the-counter items, acupuncture, massage therapy, personal training (4 visits or $225 allowance), nutritional/dietary counseling	Not available		Not available	
Over-the-Counter (OTC) Catalog[2]	Not available		$0 copayment for qualified OTC items in-network	$200 annual deductible, then 90% of the allowed amount for qualified OTC items out-of-network
			$100 combined in- and out-of-network quarterly allowance Two orders per quarter No rollover on quarterly allowance	
Fitness with One Pass™ [2]	$0 in-network	Up to $10 reimbursement annually out-of-network	$0 in-network	Up to $10 reimbursement annually out-of-network
MD Live® Virtual Visit[2] For medical services	$0		$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.		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		$130 per incident $100,000 Maximum benefit	

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Your Costs	Network Health Select (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	Network Health Choice (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	Network Health Armor (Excludes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Recovery and Rehabilitation Services			
Durable Medical Equipment Such as traditional insulin pumps[1], CPAP machines, prosthetic devices[1], etc. *Deductible applies*	20% of the allowed amount	20% of the allowed amount	20% of the allowed amount
Durable Medical Equipment for Home Infusion *Deductible applies out-of-network*	0% of the allowed amount	0% of the allowed amount	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 *Deductible applies out-of-network*	$20	$15	$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 *Deductible applies out-of-network*	$60	$50	$40
Medicare-Covered Home Health Care Visits[1] *Deductible applies*	$0	$0	$0
Cancer Services			
Chemotherapy[1] *Deductible applies*	20% of the allowed amount	20% of the allowed amount	20% of the allowed amount
Radiation Therapy[1] *Deductible applies*	20% of the allowed amount	20% of the allowed amount	20% of the allowed amount
Diabetic Services			
Diabetes Monitoring Supplies and Test Strips Accu-Chek and FreeStyle test strips FreeStyle Libre and Dexcom continuous glucose monitoring devices and supplies[1] obtained through your pharmacy Must have a diabetic diagnosis All other brands are not covered *Deductible applies out-of-network*	$0 for up to a 90-day supply	$0 for up to a 90-day supply	$0 for up to a 90-day supply
Diabetic Shoe Inserts *Deductible applies*	$10	$10	$10
Diabetes Management Diabetes self-management training teaches you to cope with and manage your diabetes	$0	$0	$0

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2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health Select (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Part B Insulin[1] One-month supply	No more than $35
Renal Services	
Dialysis *Deductible applies*	20% of the allowed amount

SUMMARY OF BENEFITS

Your Costs	Network Health Choice (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	Network Health Armor (Excludes pharmacy)
Part B Insulin[1] One-month supply	No more than $35	No more than $35
Renal Services		
Dialysis *Deductible applies*	20% of the allowed amount	20% of the allowed amount

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2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Drug Costs		Network Health Select (Includes pharmacy)	Network Health Choice (Includes pharmacy)
Yearly Drug Deductible You pay the full amount of your covered Part D drugs until the deductible is met		$330 Applies to Tiers 2 - 5	$300 Applies to Tiers 2 - 5
INITIAL COVERAGE – Cost share applies after deductible is met. Amount shown is the maximum you will pay. You may pay less.			
PREFERRED	**30-Day Supply** Preferred Pharmacy or Preferred Mail Order Pharmacy	$1 for Tier 1 $8 for Tier 2 20% for Tier 3 37% for Tier 4 29% for Tier 5	$1 for Tier 1 $8 for Tier 2 22% for Tier 3 31% for Tier 4 30% for Tier 5
PREFERRED	**3-Month Supply** Preferred Pharmacy 100-Day Supply for Tier 1 90-Day Supply for Tiers 2-4	$2 for Tier 1 $20 for Tier 2 20% for Tier 3 37% for Tier 4 Tier 5 is not available	$2 for Tier 1 $20 for Tier 2 22% for Tier 3 31% for Tier 4 Tier 5 is not available
PREFERRED	**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 20% for Tier 3 37% for Tier 4 Tier 5 is not available	$0 for Tier 1 $0 for Tier 2 22% for Tier 3 31% 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 37% for Tier 4 29% for Tier 5	$8 for Tier 1 $17 for Tier 2 25% for Tier 3 31% for Tier 4 30% for Tier 5
STANDARD	**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 37% for Tier 4 Tier 5 is not available	$20 for Tier 1 $42 for Tier 2 25% for Tier 3 31% for Tier 4 Tier 5 is not available
Part D Insulin and Vaccines			
Part D Insulin[1] One-month supply		No more than $35	No more than $35
Part D Vaccines Shingrix, RSV, all other adult ACIP[2] recommended vaccines		$0	$0
CATASTROPHIC COVERAGE			
You enter catastrophic coverage when your total out-of-pocket costs reach $2,400. You pay $0.			

[1]Service may require prior authorization

[2]Advisory Committee on Immunization Practices

NOTES

2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health PlusRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Monthly Premium	$105
Monthly Part B Premium Giveback[2] 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[1]	$175 per day, days 1 - 5 $0 days 6 and beyond
Outpatient Hospital Services[1]	$350
Ambulatory Surgical Center[1]	$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[1], 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[1] Such as ultrasound, EKG, stress test	$25
Labs What you pay may be based on the service received and/or where you are treated	$0 or $5
Diagnostic Radiology Services[1] Advanced imaging (PET, CAT, MRI, MRA, NUC Scans)	$100

SUMMARY OF BENEFITS

Your Costs	Network Health PremierRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Monthly Premium	$257
Monthly Part B Premium Giveback[2] 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[1]	$75 per day, days 1 - 5 $0 days 6 and beyond
Outpatient Hospital Services[1]	$0
Ambulatory Surgical Center[1]	$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[1], 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[1] Such as ultrasound, EKG, stress test	$0
Labs What you pay may be based on the service received and/or where you are treated	$0
Diagnostic Radiology Services[1] Advanced imaging (PET, CAT, MRI, MRA, NUC Scans)	$0

2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Costs	Network Health PlusRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
X-rays	$25	
Hearing Services		
Routine Hearing Exam[2]	$0 in-network	$200 deductible, then 90% of the allowed amount out-of-network
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues	$25	
Hearing Aids[2] Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device in-network	$4,000 deductible then 90% of the allowed amount per pair of hearing aids out-of-network. Reimbursement up to a maximum of $75
Dental Services		
Dental Services[2] 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% of the allowed amount comprehensive coverage in-network.	Member pays 80% of the allowed amount out-of-network
	$750 combined in- and out-of-network annual maximum	
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth	$25	
Optional Comprehensive Dental Coverage[2]	$39 monthly premium $1,000 combined in- and out-of-network annual maximum	
Vision Services		
Annual Routine Vision Exam[2]	$10 in-network	$40 reimbursement out-of-network
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye	$25	
Post-Cataract Eyewear One pair of eyeglasses or contact lenses after each cataract surgery	$0	
Additional Eyewear[2] At EyeMed providers	Not covered	
Mental Health/Substance Abuse		
Outpatient Mental Health Individual or group therapy	$35	
Inpatient Mental Health[1]	$150 per day, days 1 - 10 $0 days 11 and beyond	
Opioid Treatment Services	$35	
Substance Abuse Services Outpatient individual or group therapy	$20	

SUMMARY OF BENEFITS

Your Costs	Network Health PremierRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
X-rays	$0	
Hearing Services		
Routine Hearing Exam[2]	$0 in-network	$200 deductible, then 90% of the allowed amount out-of-network
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues	$0	
Hearing Aids[2] Maximum of two hearing aids per year Required hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device in-network	$4,000 deductible then 90% of the allowed amount per pair of hearing aids out-of-network. Reimbursement up to a maximum of $75
Dental Services		
Dental Services[2] 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, exam and fluoride treatment per year for $30	$100 reimbursement out-of-network
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth	$0	
Optional Comprehensive Dental Coverage[2]	$39 monthly premium $1,000 combined in- and out-of-network annual maximum	
Vision Services		
Annual Routine Vision Exam[2]	$10 in-network	$40 reimbursement out-of-network
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye	$0	
Post-Cataract Eyewear One pair of eyeglasses or contact lenses after each cataract surgery	$0	
Additional Eyewear[2] At EyeMed providers	Not covered	
Mental Health/Substance Abuse		
Outpatient Mental Health Individual or group therapy	$0	
Inpatient Mental Health[1]	$0	
Opioid Treatment Services	$0	
Substance Abuse Services Outpatient individual or group therapy	$0	

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Your Costs	Network Health PlusRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
Continued Care Services		
Skilled Nursing Facility[1]	$20 per day, days 1 - 20 $221 per day, days 21 – 40 $0 days 41 - 100	
Outpatient Physical[1], Occupational[1], Speech Therapy	$40	
Transportation Services		
Air and Ground Ambulance Services	$250	
Drug Coverage		
Medicare Part B Drugs[1]	20% of the total cost	
Medicare Part D Drugs[1] See Your Drug Costs table for specific drug tier costs	Covered at in-network pharmacies only	
Additional Benefits		
Pick Your Perks[2] Reimbursement for the following extra benefits: dental services, vision hardware, 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 (OTC) Catalog[2]	$0 copayment for qualified OTC items in-network	$200 annual deductible, then 90% of the allowed amount for qualified OTC items out-of-network
	$75 combined in- and out-of-network quarterly allowance Two orders per quarter No rollover on quarterly allowance	
Fitness with One Pass™ [2]	$0 in-network	Up to $10 reimbursement out-of-network
MD Live® Virtual Visit[2] 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.	
Recovery and Rehabilitation Services		
International Emergency Coverage View the *Evidence of Coverage* at networkhealth.com/medicare/plan-materials for details	$130 per incident $100,000 Maximum benefit	
Durable Medical Equipment Such as traditional insulin pumps[1], CPAP machines, prosthetic devices[1], etc.	20% of the allowed amount	
Durable Medical Equipment for Home Infusion	0% of the allowed amount	

SUMMARY OF BENEFITS

Your Costs	Network Health PremierRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]	
Continued Care Services		
Skilled Nursing Facility[1]	$0	
Outpatient Physical[1], Occupational[1], Speech Therapy	$20	
Transportation Services		
Air and Ground Ambulance Services	$0	
Drug Coverage		
Medicare Part B Drugs[1]	20% of the total cost	
Medicare Part D Drugs[1] See Your Drug Costs table for specific drug tier costs	Covered at in-network pharmacies only	
Additional Benefits		
Pick Your Perks[2] Reimbursement for the following extra benefits: dental services, vision hardware, 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 (OTC) Catalog[2]	$0 copayment for qualified OTC items in-network	$200 annual deductible, then 90% of the allowed amount for qualified OTC items out-of-network
	$75 combined in- and out-of-network quarterly allowance Two orders per quarter No rollover on quarterly allowance	
Fitness with One Pass™ [2]	$0 in-network	Up to $10 reimbursement out-of-network
MD Live® Virtual Visit[2] 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.	
Recovery and Rehabilitation Services		
International Emergency Coverage View the *Evidence of Coverage* at networkhealth.com/medicare/plan-materials for details	$130 per incident $100,000 Maximum benefit	
Durable Medical Equipment Such as traditional insulin pumps[1], CPAP machines, prosthetic devices[1], etc.	$0	
Durable Medical Equipment for Home Infusion	$0	

Your Costs	Network Health PlusRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Medicare-Covered Chiropractic Services Manipulation of the spine to correct misalignment of one or more of the bones of your spine	$20
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[1]	$0
Cancer Services	
Chemotherapy[1]	20% of the allowed amount
Radiation Therapy[1]	$60
Diabetic Services	
Diabetes Monitoring Supplies and Test Strips Accu-Chek and FreeStyle test strips FreeStyle Libre and Dexcom continuous glucose monitoring devices and supplies[1] obtained through your pharmacy Must have a diabetic diagnosis All other brands are not covered	$0 for up to a 90-day supply
Diabetic Shoe Inserts	$10
Diabetes Management Diabetes self-management training teaches you to cope with and manage your diabetes	$0
Part B Insulin[1] One-month supply	No more than $35
Renal Services	
Dialysis	20% of the allowed amount

Your Costs	Network Health PremierRx (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS[3]
Medicare-Covered Chiropractic Services Manipulation of the spine to correct misalignment of one or more of the bones of your spine	$20
Medicare-Covered Acupuncture For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	$20
Medicare-Covered Home Health Care Visits[1]	$0
Cancer Services	
Chemotherapy[1]	20% of the allowed amount
Radiation Therapy[1]	$0
Diabetic Services	
Diabetes Monitoring Supplies and Test Strips Accu-Chek and FreeStyle test strips FreeStyle Libre and Dexcom continuous glucose monitoring devices and supplies[1] obtained through your pharmacy Must have a diabetic diagnosis All other brands are not covered	$0 for up to a 90-day supply
Diabetic Shoe Inserts	$0
Diabetes Management Diabetes self-management training teaches you to cope with and manage your diabetes	$0
Part B Insulin[1] One-month supply	No more than $35
Renal Services	
Dialysis	20% of the allowed amount

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2027 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

Your Drug Costs		Network Health Plus Rx (Includes pharmacy)	Network Health PremierRx (Includes pharmacy)
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 – Cost share applies after deductible is met. 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 22% for Tier 3 32% for Tier 4 29% for Tier 5	$0 for Tier 1 $8 for Tier 2 22% for Tier 3 31% for Tier 4 29% for Tier 5
PREFERRED	**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 22% for Tier 3 32% for Tier 4 Tier 5 is not available	$0 for Tier 1 $20 for Tier 2 22% for Tier 3 31% for Tier 4 Tier 5 is not available
PREFERRED	**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 22% for Tier 3 32% for Tier 4 Tier 5 is not available	$0 for Tier 1 $0 for Tier 2 22% for Tier 3 31% 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 32% for Tier 4 29% for Tier 5	$8 for Tier 1 $17 for Tier 2 25% for Tier 3 31% for Tier 4 29% for Tier 5
STANDARD	**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 32% for Tier 4 Tier 5 is not available	$20 for Tier 1 $42 for Tier 2 25% for Tier 3 31% for Tier 4 Tier 5 is not available
Part D Insulin and Vaccines			
Part D Insulin[1] One-month supply		No more than $35	No more than $35
Part D Vaccines Shingrix, RSV, all other adult ACIP[2] recommended vaccines		$0	$0
CATASTROPHIC COVERAGE			
You enter catastrophic coverage when your total out-of-pocket costs reach $2,400. You pay $0.			

[1]Service may require prior authorization

[2]Advisory Committee on Immunization Practices

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, 2028.

- [ ] 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.

NOTES

NOTES

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:
  - Qualified sign language interpreters
  - 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:
  - Qualified interpreters
  - 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

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.

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 shtesë 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 تحدث إلى مقدم (711) 800-378-5234 اتصل على الرقم الخدمة.

Chinese: 如果您说中文，我们将免费为您提供语言协助服务。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 Sprachassistenzdienste 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 निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध 800-378-5234 (TTY : 711) पर कॉल करें या 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 보조 기구 및 서비스도 무료로 제공됩니다. 800-378-5234 (TTY : 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-378-5234 (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. H5215_**6074**-01-0526_M