network health

2027 Summary of Benefits

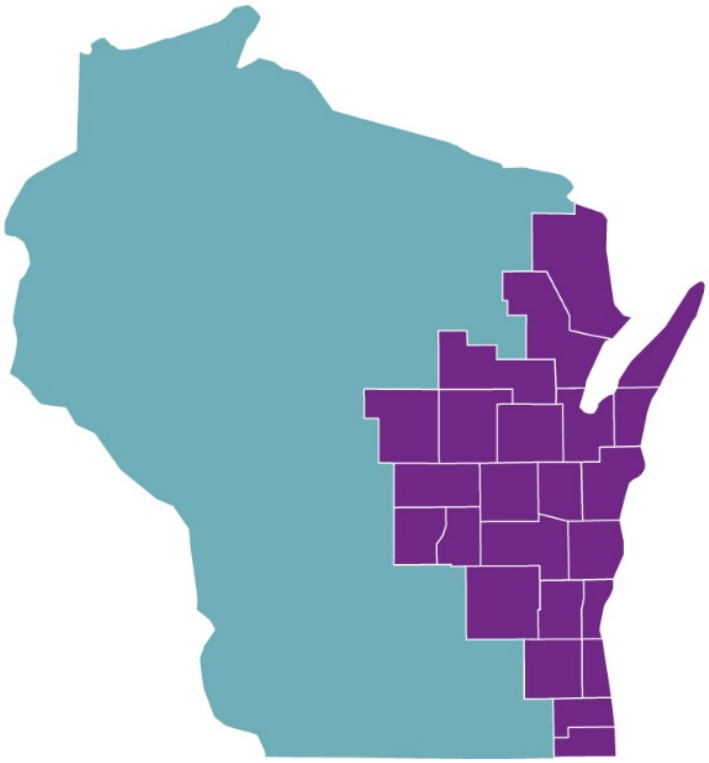
Dual-Eligible Special Needs Plan (PPO D-SNP)

Network Health Cares

2027 NETWORK HEALTH CARES (PPO D-SNP)

SERVICE AREA AND ELIGIBILITY

To be eligible to join Network Health's PPO D-SNP plan described in this booklet, you must be enrolled in Medicare Part A and Medicare Part B, enrolled in Wisconsin Medicaid and live in the service area. This Summary of Benefits applies to the Network Health Cares plan offered in the following counties in Wisconsin—Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kenosha, Kewaunee, Manitowoc, Marinette, Milwaukee, Marquette, Oconto, Outagamie, Ozaukee, Portage, Racine, Shawano, Sheboygan, Washington, Waukesha, Waupaca, Waushara and Winnebago.



WHAT IS A SUMMARY OF BENEFITS?

This booklet gives you a summary of what we cover and what you pay on the Network Health Cares (PPO D-SNP) plan. It doesn't list every service we cover or every limitation or exclusion. A complete list of services can be found in the plan-specific *Evidence of Coverage* at **networkhealth.com/medicare/plan-materials**. Contact the member experience team for a printed copy.

WHAT IS A DUAL-ELIGIBLE SPECIAL NEEDS PLAN (PPO D-SNP)?

This Medicare Advantage plan is specifically designed for people who are eligible for both Medicare and Medicaid (called dual-eligible). How much Medicaid covers depends on your income, resources and other factors. Some people get full Medicaid benefits and some only get help to pay for certain Medicare costs, including premiums, deductibles, coinsurance or copayments.

SUMMARY OF BENEFITS

CONTACT NETWORK HEALTH

By Phone	Sales Team – **800-983-7587** Member Experience Team – **855-653-4363** 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]Services may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits-snp** for more information, this is not a medical benefit.

Your Costs	Network Health Cares		Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost**		
Monthly Premium	$0		Premiums, deductibles and payment limitations depend on the type of coverage you have. For benefit questions, contact Forward Health Member Services at **800-362-3002** or consult your *Forward Health Enrollment and Benefits Handbook*.
Annual Medical Deductible	In 2026 the amounts were: $0-$283 depending on your level of Medicaid eligibility. These amounts may change for 2027.		
Annual Medical Maximum Out-of-Pocket	$9,850 for services you receive from in-network providers $14,800 for services you receive from any provider, your limit for services received from in-network providers will count toward this limit		
Hospital Services			
Inpatient Hospital Services[1]	In 2026 the amounts for each admission were: Days 1-60: $0-$1,736 deductible Days 61-90: $0-$434 per day Days 91 and beyond: $0-$868 per day (This plan covers 60 lifetime reserve days) These amounts may change for 2027.		Covered
Outpatient Hospital[1]	0% to 20% of the allowed amount		Covered
Ambulatory Surgical Center[1]	0% to 20% of the allowed amount		Covered
General Services			
Primary Care Provider Visit	0% to 20% of the allowed amount		Covered
Specialist Visit	0% to 20% of the allowed amount		Covered
Preventive Care			
Preventive Care Visits	$0 in-network	0% to 20% of the allowed amount out-of-network	Covered
Annual Medicare Wellness Visit	$0 in-network	0% to 20% of the allowed amount out-of-network	Covered
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit		Covered
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	$0 in- and out-of-network		Covered

Your Costs	Network Health Cares		Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost		
Medicare-Covered Vaccines Hepatitis B[1], all other Part B	$0 in-network	0% to 20% of the allowed amount out-of-network	Covered
Emergency Care			
Emergency Room Visit	0% to 20% of the allowed amount (up to $115)		Coverage may not be available outside the state of Wisconsin
Urgent Care			
Urgent Care Visit Free-standing facility	0% to 20% of the allowed amount (up to $40)		Covered
Diagnostic Services			
Diagnostic Tests[1] Such as ultrasound, EKG, stress test	0% to 20% of the allowed amount		Covered
Labs What you pay may be based on the service received and/or where you are treated	0% to 20% of the allowed amount		Covered
Diagnostic Radiology Services[1] Advanced imaging (PET, CAT, MRI, MRA, NUC Scans)	0% to 20% of the allowed amount		Covered
X-rays	0% to 20% of the allowed amount		Covered
Hearing Services			
Routine Hearing Exam[2]	$0 in-network	$200 deductible, then 90% of the allowed amount out-of-network	Covered
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues	0% to 20% of the allowed amount		Covered

Your Costs	Network Health Cares		Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost		
Hearing Aids[2] Maximum of two hearing aids per year. Required hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device, through TruHearing	$4,000 deductible then 90% of the allowed amount per pair of hearing aids out-of-network. Reimbursement up to a maximum of $75	Covered
Dental Services			
Preventive and Comprehensive Dental Coverage[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.	$0 Cleaning (twice a year) $0 Dental X-ray(s) (bitewing 1 per year, full mouth 1 every 5 years) $0 Oral Exam (twice a year) $0 Basic Restorative Services $0 for major services received at in-network providers (endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery, other services), 50% of the allowed amount out-of-network $3,000 combined in- and out-of-network annual maximum		Covered
Medicare-Covered Dental Services Does not include services in connection with care, treatment filling, removal or replacement of teeth	0% to 20% of the allowed amount		Covered
Vision Services			
Annual Routine Vision Exam[2]	$0 in-network, or	$40 reimbursement out-of-network	Covered
Diagnostic Eye Exam To diagnose and treat diseases and conditions of the eye	0% to 20% of the allowed amount		Covered

Your Costs	Network Health Cares		Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost		
Post-Cataract Eyewear One pair of basic eyeglasses or contact lenses after each cataract surgery	0% to 20% of the allowed amount		Covered
Additional Eyewear[2] At EyeMed providers	$400 allowance in-network, or	$400 reimbursement out-of-network	Covered
Mental Health/Substance Abuse			
Outpatient Mental Health Individual or group therapy	0% to 20% of the allowed amount		Covered
Inpatient Mental Health[1]	In 2026 the amounts for each admission were: Days 1-60: $0-$1,736 deductible Days 61-90: $0-$434 per day Days 91 and beyond: $0-$868 per day (This plan covers 60 lifetime reserve days) These amounts may change for 2027.		Covered
Opioid Treatment Services	0% to 20% of the allowed amount		Covered
Substance Abuse Services Outpatient individual or group therapy	0% to 20% of the allowed amount		Covered
Continued Care Services			
Skilled Nursing Facility[1]	In 2026 the amounts were: $0 per day, days 1-20 $0-$217 per day, days 21-100 These amounts may change for 2027.		Covered
Outpatient Physical[1], Occupational[1], Speech Therapy	0% to 20% of the allowed amount		Covered
Transportation Services			
Air and Ground Ambulance Services	0% to 20% of the allowed amount		Covered
Non-Emergency Transportation[2] One-way trips with Aryv	0% of the allowed amount in-network	90% of the allowed amount out-of-network	Covered
	Up to 52 one-way trips, anywhere within the Network Health Medicare Advantage Plan service area		

Your Costs	Network Health Cares		Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost		
Drug Coverage			
Medicare Part B Drugs[1]	0% to 20% of the allowed amount		Covered
Medicare Part D Drugs[1] See Your Drug Costs table for specific drug tier costs	Covered		Covered
Additional Benefits			
Over-the-Counter (OTC) Catalog[2]	$0 copayment for OTC items in-network	$200 annual deductible, then 90% of the allowed amount for qualified OTC items out-of-network	Covered
	$192 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 annual reimbursement out-of-network	Not covered
MD Live® Virtual Visit[2] For medical services	$0		Not covered
Meal Delivery[2] Meal delivery following a qualified hospital observation stay, inpatient hospital stay or skilled nursing facility stay	$0 for home-delivered meals in-network	$500 annual deductible, then 90% of the allowed amount for home-delivered meals out-of-network. Reimbursement up to a maximum of $600 annually.	Not covered
	Up to 28 meals per qualifying stay		

Your Costs	Network Health Cares		Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost		
In-Home Support[2] Assistance with organization, light housework, technology and transportation	$0 for in-home support services in-network	$1,500 deductible, then 90% of the allowed amount for in-home support services out-of-network	Not covered
	Up to 120 hours annually		
HRA Rewards	Earn a $50 reward by completing your annual health risk assessment		Not covered
Travel Coverage			
Travel within the United States	Receive in-network coverage when you see a provider outside Wisconsin, anywhere in the United States		Coverage may not be available outside the state of Wisconsin
International Emergency Coverage View the *Evidence of Coverage* for details at networkhealth.com/medicare/plan-materials	$130 per incident $100,000 Maximum benefit		Not covered
Recovery and Rehabilitation Services			
Durable Medical Equipment Such as traditional insulin pumps[1], CPAP machines, prosthetic devices[1], etc.	0% to 20% of the allowed amount		Covered
Medicare-Covered Chiropractic Services Manipulation of the spine to correct misalignment of one or more of the bones of your spine	0% to 20% of the allowed amount		Covered
Medicare-Covered Acupuncture For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	0% to 20% of the allowed amount		Covered
Medicare-Covered Home Health Care Visits[1]	$0		Covered

Your Costs	Network Health Cares	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0% to 20% of the cost	
Cancer Services		
Chemotherapy[1]	0% to 20% of the allowed amount	Covered
Radiation Therapy[1]	0% to 20% of the allowed amount	Covered
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% to 20% of the allowed amount	Covered
Diabetic Shoe Inserts	0% to 20% of the allowed amount	Covered
Diabetes Management Diabetes self-management training teaches you to cope with and manage your diabetes	0% to 20% of the allowed amount	Not covered
Part B Insulin[1] One-month supply	No more than $35	Covered
Renal Services		
Dialysis	0% to 20% of the allowed amount	Covered

PRESCRIPTION DRUG BENEFITS

After you reach your yearly deductible of $0 – $700 for your covered Part D drugs, you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or in-network mail order pharmacies. If you are eligible for Medicare cost sharing assistance under Medicaid, you will need to use a pharmacy located in Wisconsin. Only pharmacies located in Wisconsin can work with your Medicaid benefit.

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use an in-network pharmacy. If it is necessary to use an out-of-network pharmacy, please check first with member experience because you may pay more than you pay at an in-network pharmacy.

Your Drug Costs	Network Health Cares (includes pharmacy)	Medicaid
Initial Coverage – Amount shown is the maximum you will pay. If you receive Extra Help, depending on your income level, your actual cost share may be less.		
30-Day Supply In-Network Pharmacy or Mail Order Pharmacy	25% of the total cost	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs
3-Month Supply In-Network Pharmacy or Mail Order Pharmacy	25% of the total cost	
Part D Insulin and Vaccines		
Part D Insulin[1] One-month supply	No more than $35	Covered
Part D Vaccines Shingrix, RSV, all other 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]Services 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 experience representative at **855-653-4363** (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 **855-653-4363** (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

- ☐ 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. In addition, you may pay a higher copayment for services received by non-contracted providers.
- ☐ This plan is a dual-eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

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: 855-653-4363
(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 855-653-4363 (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 855-653-4363 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic: إذا كنت تتحدث اللغة العربية، فستتوفر تنبيه: كما تتوفر وسائل لك خدمات المساعدة اللغوية المجانية. مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن 4363-653- اتصل على الرقم الوصول إليها مجانًا. 855 (711). أو تحدث إلى مقدم 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 855-653-4363（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 855-653-4363 (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 855-653-4363 (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 855-653-4363 (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 855-653-4363 (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. 855-653-4363 (TTY : 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-653-4363 (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 855-653-4363 (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 855-653-4363 (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 855-653-4363 (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 855-653-4363 (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 855-653-4363 (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 855-653-4363 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.



800-983-7587 • TTY 711

networkhealth.com

Network Health Cares is a PPO D-SNP plan with a Medicare contract and a contract with the Wisconsin Medicaid program. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal. 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_**6076**-01-0526_M