network health

2025 Summary of Benefits

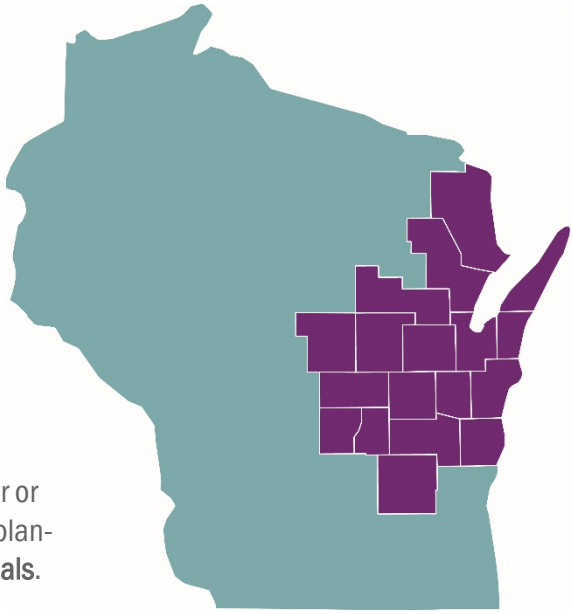
Network Health Cares

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

2025 NETWORK HEALTH CARES (PPO D-SNP)

SERVICE AREA AND ELIGIBILITY

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



WHAT IS A SUMMARY OF BENEFITS?

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

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

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

CONTACT NETWORK HEALTH

By Phone	Sales Department – **800-983-7587** Member Experience Team – **855-653-4363** TTY/TDD Users – **800-947-3529**
Online	**networkhealth.com**
By Mail or In Person	**Network Health** **1570 Midway Pl.** **Menasha, WI 54952**
Hours of Operation	• Normal office hours are Monday–Friday, 8 a.m. to 5 p.m. • Network Health is closed on New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve Day and Christmas Day. • From October 1–March 31, you can call the sales department and the member experience team seven days a week from 8 a.m. to 8 p.m., Central Time. From April 1–September 30, we are available Monday–Friday, from 8 a.m. to 8 p.m., Central Time.
Additional Resources	**Medicare – Available 24 hours a day, seven days a week** For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, seven days a week.

SUMMARY OF BENEFITS

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) **If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.**	
Monthly Premium	$0	Premiums, deductibles and payment limitations depend on the type of coverage you have. For benefit questions, contact Forward Health Member Services at **800-362-3002** or consult your *Forward Health Enrollment and Benefits Handbook*.
Monthly Part B Premium Giveback[2] You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback	$2.50 per month	
Annual Medical Deductible	In 2024 the amounts were: $0-$240 depending on your level of Medicaid eligibility. These amounts may change for 2025.	
Annual Maximum Out-of-Pocket (Does not include Part D prescription drugs)	$8,300 for services you receive from in-network providers $12,450 for services you receive from any provider, your limit for services received from in-network providers will count toward this limit	
Hospital Services		
Inpatient Hospital Services[1] Per admission	In 2024 the amounts for each admission were: Days 1-60: $0-$1,632 deductible Days 61-90: $0-$408 per day Days 91 and beyond: $0-$816 per day (This plan covers 60 lifetime reserve days) These amounts may change for 2025.	Covered
Outpatient Hospital[1]	0% to 20% of the total cost	Covered
Ambulatory Surgical Center[1]	0% to 20% of the total cost	Covered
General Services		
Primary Care Provider Visit	0% to 20% of the total cost	Covered
Specialist Visit	0% to 20% of the total cost	Covered
Preventive Care		
Preventive Care Visits*	$0 in-network 0% to 20% of the total cost out-of-network	Covered
Annual Routine Physical	Not Covered	Covered
Physician Telehealth Services	Virtual primary care and urgent care services cost the same as an in-person visit	Covered
Medicare-Covered Vaccines Flu, pneumonia, COVID-19	$0 in-network 0% to 20% of the total cost out-of-network	Covered
Medicare-Covered Vaccines Hepatitis B, all other Part B	$0 in-network 0% to 20% of the total cost out-of-network	Covered

*Includes abdominal aortic aneurysm screening, alcohol misuse screening and counseling, annual wellness visit, bone mass measurement, breast cancer screening, cardiovascular disease screening, cardiovascular disease risk reduction visit, cervical and vaginal cancer screening, colorectal cancer screening (screening colonoscopy, fecal occult blood test, flexible sigmoidoscopy), depression screening, diabetes screening, glaucoma screening, HIV screening, lung cancer screening, medical nutrition therapy services, Medicare Diabetes Prevention Program, obesity screening and therapy, prostate cancer screening, screening for sexually transmitted infections and counseling, smoking and tobacco use cessation counseling, one time Welcome to Medicare preventive visit.

[1]Services may require prior authorization.

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

2025 NETWORK HEALTH CARES (PPO D-SNP)

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Emergency Care		
Emergency Room Visit	0% to 20% of the total cost (up to $110)	Coverage may not be available outside the state of Wisconsin
Urgent Care		
Urgent Care Visit Free-standing facility	0% to 20% of the total cost (up to $45)	Covered
Diagnostic Services		
Diagnostic Tests[1] Such as ultrasound, EKG, stress test	0% to 20% of the total cost	Covered
Labs What you pay may be based on the service received and/or where you are treated	0% to 20% of the total cost	Covered
Diagnostic Radiology Services[1] Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	0% to 20% of the total cost	Covered
X-rays	0% to 20% of the total cost	Covered
Hearing Services		
Routine Hearing Exam[2]	$0 in-network, or $40 out-of-network	Covered
Diagnostic Hearing Exam Exam to diagnose and treat hearing issues	0% to 20% of the total cost	Covered
Hearing Aids[2] Maximum of two hearing aids per year Hearing aid evaluation with TruHearing, fitting included	$495 to $1,695 per device, hearing aids must be purchased through TruHearing	Covered
Dental Services		
Preventive and Comprehensive Dental Coverage[2]	$0 Cleaning (twice a year) $0 Dental X-ray(s) (bitewing 1 per year, full mouth 1 every 5 years) $0 Oral Exam (twice a year) $0 Basic Restorative Services $0 for major services received at in-network providers (endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery, other services), 50% coverage out-of-network $3,000 combined in- and out-of-network annual maximum	Covered

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

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Medicare-Covered Dental Services Does not include services in connection with care, treatment, filling, removal or replacement of teeth	0% to 20% of the total cost	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 total cost	Covered
Post-Cataract Eyewear One pair of basic eyeglasses or contact lenses after each cataract surgery	0% to 20% of the total cost	Covered
Additional Eyewear[2] At EyeMed providers	$400 allowance in-network, or $400 reimbursement out-of-network	Covered
Mental Health/Substance Abuse		
Outpatient Mental Health Individual or group therapy	0% to 20% of the total cost	Covered
Inpatient Mental Health[1] Per admission	In 2024 the amounts for each admission were: Days 1-60: $0-$1,632 deductible Days 61-90: $0-$408 per day Days 91 and beyond: $0-$816 per day (This plan covers 60 lifetime reserve days) These amounts may change for 2025.	Covered
Opioid Treatment Services	0% to 20% of the total cost	Covered
Substance Abuse Services Outpatient individual or group therapy	0% to 20% of the total cost	Covered
Continued Care Services		
Skilled Nursing Facility[1] Per admission Once you reach your maximum out-of-pocket, you will pay $0 per day	In 2024 the amounts were: $0 per day, days 1-20 $0-$204 per day, days 21-100 These amounts may change for 2025.	Covered
Outpatient Physical[1]**, Occupational**[1]**, Speech Therapy**	0% to 20% of the total cost	Covered
Transportation Services		
Air and Ground Ambulance Services	0% to 20% of the total cost	Covered

[1]Services may require prior authorization.

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

2025 NETWORK HEALTH CARES (PPO D-SNP)

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Non-Emergency Transportation[2,3] One-way trips with Aryv	36 one-way trips, anywhere within the Network Health Medicare Advantage Plan service area. Additionally includes 24 one-way trips for members with ESRD to get to and from dialysis.	Covered
Drug Coverage		
Medicare Part B Drugs[1] Plan will apply the CMS published adjusted beneficiary coinsurance as required under the Inflation Reduction Act.	0% to 20% of the total cost	Covered
Medicare Part D Drugs[1] See page 8 for specific drug tier costs	Covered	Covered
Additional Benefits		
Over-the-Counter Catalog[2]	$225 per quarter Two orders per quarter No rollover on quarterly allowance	Limited coverage
Fitness with One Pass™[2]	Included	Not covered
MDLIVE® Virtual Visit[2] For medical services	$0	Not covered
Meal Delivery[2] Following a hospital observation stay, qualified inpatient hospital stay or skilled nursing facility stay	28 meals	Not covered
Fresh Produce or Pantry Boxes[2] For members screened by their care manager and diagnosed with diabetes, congestive heart failure or obesity	6 boxes annually	Not covered
In-Home Support[2] Assistance with organization, light housework, technology and transportation	60 hours annually	Not covered
HRA Rewards	Earn a $50 reward by completing your annual health risk assessment	Not covered
Travel Coverage		
Travel within the United States	Receive in-network coverage when you see a provider outside Wisconsin, anywhere in the United States	Coverage may not be available outside the state of Wisconsin

[1]Services may require prior authorization.

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

[3]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.

Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
International Emergency Coverage View the *Evidence of Coverage* for details at networkhealth.com/medicare/plan-materials	$125 per incident $100,000 Maximum benefit	Not covered
Recovery and Rehabilitation Services		
Durable Medical Equipment[1] Such as insulin pumps, CPAP machines, prosthetic devices	0% to 20% of the total cost	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 total cost	Covered
Medicare-Covered Acupuncture For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	0% to 20% of the total cost	Covered
Medicare-Covered Home Health Care Visits[1]	$0	Covered
Cancer Services		
Chemotherapy[1]	0% to 20% of the total cost	Covered
Radiation Therapy[1] Per service	0% to 20% of the total cost	Covered
Acupuncture[3] Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting	$0	Not covered
Diabetic Services		
Diabetes Monitoring Supplies and Test Strips OneTouch® and FreeStyle test strips Continuous Glucose Monitoring supplies[1] limited to eligible FreeStyle Libre® and Dexcom® obtained through your pharmacy. All other brands are not covered.	0% to 20% of the total cost	Covered – One Touch
Diabetic Shoe Inserts Coinsurance per pair	0% to 20% of the total cost	Covered

[1]Services may require prior authorization.

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

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Your Costs	Network Health Cares (PPO D-SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (UNLESS SPECIFIED) If you are eligible for Medicare cost sharing assistance under Medicaid, you may pay $0 for benefits that state 0%-20% of the cost.	
Diabetes Management Diabetes self-management training teaches you to cope with and manage your diabetes	0% to 20% of the total cost	Not covered
Part B Insulin One-month supply	0% to 20% of the total cost, up to $35	Covered
Renal Services		
Dialysis Per treatment	0% to 20% of the total cost	Covered

PRESCRIPTION DRUG BENEFITS

After you reach your yearly deductible of $0 – $590 for your Tier 1 drugs (all drugs), you pay the following copayments or coinsurance for your drugs. You will need to fill your prescriptions at in-network retail pharmacies or the plan's mail order pharmacy.

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

Your Drug Costs	Network Health Cares (Includes pharmacy) (PPO D-SNP)	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 One-month supply	25% of the total cost, up to $35	
Part D Vaccines Shingrix, Tdap, all other ACIP recommended vaccines	$0	$0
CATASTROPHIC COVERAGE		
You enter catastrophic coverage when your total out-of-pocket costs reach $2,000. You pay $0.		

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 800-947-3529), 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 800-947-3529) 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, 2026.
- ☐ 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 will 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.

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 800-947-3529)
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: 800-947-3529) 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: 800-947-3529) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات تنبيه: كما تتوفر وسائل مساعدة وخدمات مناسبة المساعدة اللغوية المجانية. اتصل على لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. أو تحدث إلى مقدم (800-947-3529) 855-653-4363 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 855-653-4363（文本电话：800-947-3529）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 : 800-947-3529) 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 : 800-947-3529) 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 : 800-947-3529) 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 : 800-947-3529) 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 : 800-947-3529) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-653-4363 (TTY : 800-947-3529) ຫຼືລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

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: 800-947-3529) uff odder schwetz mit dei Provider.

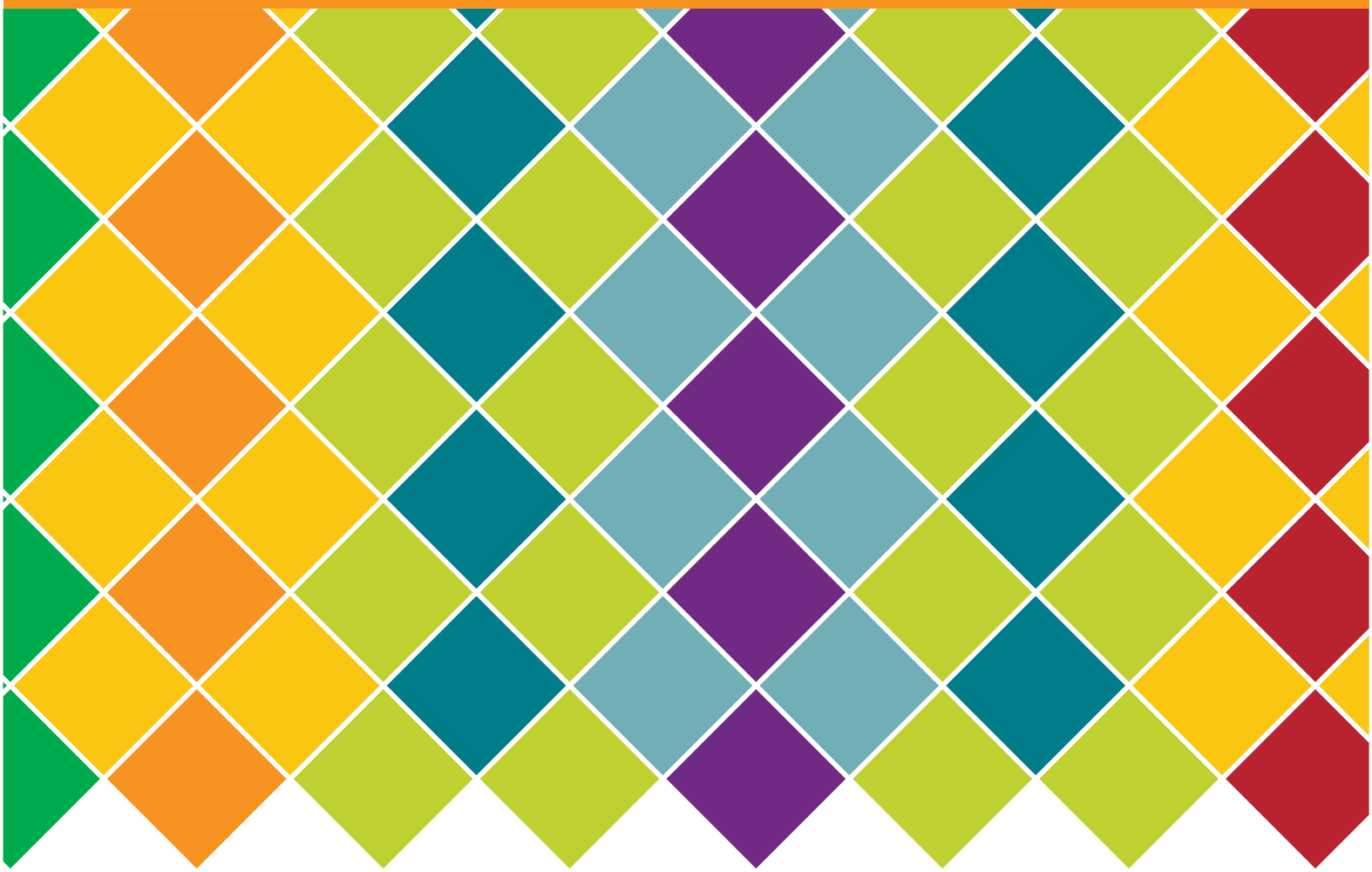
Polish: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-653-4363 (TTY : 800-947-3529) lub porozmawiaj ze swoim dostawcą.

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 : 800-947-3529) 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 : 800-947-3529) 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 : 800-947-3529) 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: 800-947-3529) hoặc trao đổi với người cung cấp dịch vụ của bạn.



network health

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