
# 2026 Summary of Benefits

## Medicare Advantage PPO Plans

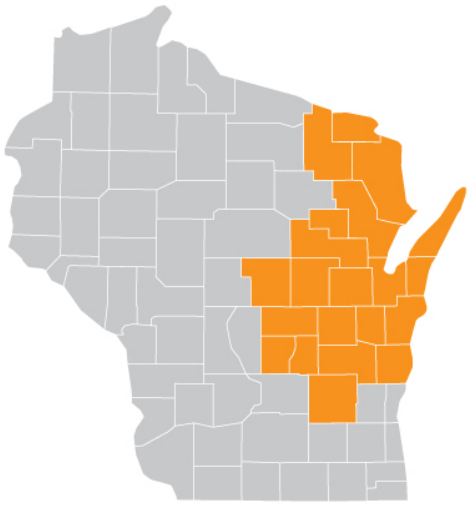
## Northeast Wisconsin

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

## SERVICE AREA AND ELIGIBILITY

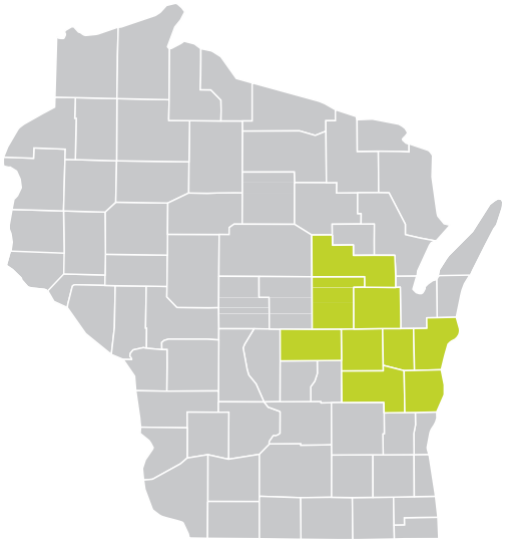
To be eligible to join the Network Health Northeast Wisconsin PPO plans described in this booklet, you must be enrolled in Medicare Part A and Part B and live in the service area.

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



**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, Memominee, Oconto, Outagamie, Portage, Shawano, Sheboygan, Waupaca, Waushara, Winnebago



**Network Health Zero**

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

# SUMMARY OF BENEFITS

## WHAT IS A SUMMARY OF BENEFITS?

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

## WHAT IS A PREFERRED PROVIDER (PPO) PLAN?

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

## CONTACT NETWORK HEALTH

| | |
|---|---|
| **By Phone** | Sales Team – **800-983-7587**<br>Member Experience Team – **800-378-5234**<br>TTY/TDD Users – **711** |
| **Online** | **networkhealth.com** |
| **By Mail or In Person** | **Network Health**<br>**1570 Midway Pl.**<br>**Menasha, WI 54952** |
| **Hours of Operation** | • Normal office hours are Monday–Friday, 8 a.m. to 5 p.m.<br>• 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.<br>• 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**<br>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. |

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

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

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

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

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

[1]Service may require prior authorization.

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

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

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

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

| Your Costs | Network Health Armor (Excludes pharmacy)<br>Please see county listing for service area.<br>YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS |
|---|---|
| **Over-the-Counter Catalog**[2] | $100 per quarter<br>Two orders per quarter<br>No rollover on quarterly allowance |
| **Fitness with One Pass™**[2] | Included |
| **MDLIVE® Virtual Visit**[2]<br>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**<br>View the Evidence of Coverage at networkhealth.com/medicare/plan-materials for details | $130 per incident<br>$100,000 Maximum benefit |
| **Recovery and Rehabilitation Services** | |
| **Durable Medical Equipment**<br>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 |
| **Medicare-Covered Chiropractic Services**<br>Manipulation of the spine to correct misalignment of one or more of the bones of your spine | $15 |
| **Medicare-Covered Acupuncture**<br>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]<br>Per service | 20% of the allowed amount |
| **Acupuncture**[3]<br>Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting | $0 |

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

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

[1]Service may require prior authorization.

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

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

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

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

[1]Service may require prior authorization.

# NOTES

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

| Your Costs | Network Health PlusRx (Includes pharmacy)<br>Please see county listing for service area.<br>YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS |
|---|---|
| **Monthly Premium** | $73 |
| **Monthly Part B Premium Giveback**[2]<br>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]<br>Per admission | $175 per day, days 1 - 5<br>$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**<br>Flu, pneumonia, COVID-19 | $0 |
| **Medicare-Covered Vaccines**<br>Hepatitis B[1], all other Part B | $0 |
| **Emergency Care** | |
| **Emergency Room Visit**<br>Copayment is waived if admitted to a U.S. hospital within 24 hours | $130 |
| **Urgent Care** | |
| **Urgent Care Visit**<br>Free-standing facility | $40 |
| **Diagnostic Services** | |
| **Diagnostic Tests**[1]<br>Such as ultrasound, EKG, stress test | $25 |

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

# SUMMARY OF BENEFITS

| Your Costs | Network Health PremierRx (Includes pharmacy)<br>Please see county listing for service area.<br>YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS |
|---|---|
| **Monthly Premium** | $226 |
| **Monthly Part B Premium Giveback**[2]<br>You must meet all eligibility requirements to receive the Medicare Part B Premium Giveback | Not included |
| **Annual Medical Deductible** | $0 |
| **Annual Maximum Out-of-Pocket**<br>(Does not include Part D prescription drugs) | $3,400 combined in- and out-of-network |
| **Hospital Services** | |
| **Inpatient Hospital Services**[1]<br>Per admission | $75 per day, days 1 - 5<br>$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**<br>Flu, pneumonia, COVID-19 | $0 |
| **Medicare-Covered Vaccines**<br>Hepatitis B[1], all other Part B | $0 |
| **Emergency Care** | |
| **Emergency Room Visit**<br>Copayment is waived if admitted to a U.S. hospital within 24 hours | $130 |
| **Urgent Care** | |
| **Urgent Care Visit**<br>Free-standing facility | $20 |
| **Diagnostic Services** | |
| **Diagnostic Tests**[1]<br>Such as ultrasound, EKG, stress test | $0 |

[1]Service may require prior authorization.

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

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

[1]Service may require prior authorization.

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

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

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

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# SUMMARY OF BENEFITS

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

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

| Your Costs | Network Health PlusRx (Includes pharmacy)<br>Please see county listing for service area.<br>YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS |
|---|---|
| **Recovery and Rehabilitation Services** | |
| **International Emergency Coverage–**<br>View the Evidence of Coverage at networkhealth.com/medicare/plan-materials for details | $130 per incident<br>$100,000 Maximum benefit |
| **Durable Medical Equipment**<br>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 |
| **Medicare-Covered Chiropractic Services**<br>Manipulation of the spine to correct misalignment of one or more of the bones of your spine | $20 |
| **Medicare-Covered Acupuncture**<br>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]**<br>Per service | $60 |
| **Acupuncture[3]**<br>Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting | $0 |
| **Diabetic Services** | |
| **Diabetes Monitoring Supplies and Test Strips**<br>Preferred test strips<br>Preferred continuous glucose monitoring devices and supplies[1] obtained through your pharmacy<br>Must have a diabetic diagnosis with insulin use<br>All other brands are not covered | $0 for up to a 90-day supply |
| **Diabetic Shoe Inserts**<br>Copayment per pair | $10 |
| **Diabetes Management**<br>Diabetes self-management training teaches you to cope with and manage your diabetes | $0 |
| **Part B Insulin[1]**<br>One-month supply | 20% of the total cost, up to $35 |
| **Renal Services** | |
| **Dialysis**<br>Per treatment | 20% of the allowed amount |

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# SUMMARY OF BENEFITS

| Your Costs | Network Health PremierRx (Includes pharmacy)<br>Please see county listing for service area.<br>YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS |
|---|---|
| **Recovery and Rehabilitation Services** | |
| **International Emergency Coverage**<br>View the Evidence of Coverage at networkhealth.com/medicare/plan-materials for details | $130 per incident<br>$100,000 Maximum benefit |
| **Durable Medical Equipment**<br>Such as traditional insulin pumps[1], CPAP machines, prosthetic devices[1], etc. | $0 |
| **Durable Medical Equipment for Home Infusion** | $0 |
| **Medicare-Covered Chiropractic Services**<br>Manipulation of the spine to correct misalignment of one or more of the bones of your spine | $20 |
| **Medicare-Covered Acupuncture**<br>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]**<br>Per service | $0 |
| **Acupuncture[3]**<br>Up to 12 visits per year are covered for members who are undergoing chemotherapy and have severe nausea and/or vomiting | $0 |
| **Diabetic Services** | |
| **Diabetes Monitoring Supplies and Test Strips**<br>Preferred test strips<br>Preferred continuous glucose monitoring devices and supplies[1] obtained through your pharmacy<br>Must have a diabetic diagnosis with insulin use<br>All other brands are not covered | $0 for up to a 90-day supply |
| **Diabetic Shoe Inserts**<br>Copayment per pair | $0 |
| **Diabetes Management**<br>Diabetes self-management training teaches you to cope with and manage your diabetes | $0 |
| **Part B Insulin[1]**<br>One-month supply | 20% of the total cost, up to $35 |
| **Renal Services** | |
| **Dialysis**<br>Per treatment | 20% of the allowed amount |

[1]Service may require prior authorization.

[2]Visit **networkhealth.com/medicare/extra-benefits** 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.

# 2026 NETWORK HEALTH NORTHEAST WISCONSIN (PPO)

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

[1]Service may require prior authorization.

# PRE-ENROLLMENT CHECKLIST

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

## Understanding the Benefits

- ☐ The *Evidence of Coverage* (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **networkhealth.com/medicare/plan-materials** or call **800-378-5234** (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.
- ☐ Review how enrolling into a Network Health Medicare Advantage plan will impact your current healthcare coverage.

## Understanding Important Rules

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

**Discrimination is Against the Law**

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

Network Health:

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

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

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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

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
اتصل على الرقم 5234-378-800 (711)
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 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 बोलतेहैं, तो आपकेलिए निः शु भाषा सहायता सेवाएं उपल होती हैं। सुलभप्रारूपोंमेंजानकारी प्रदान करनेकेलिए उपयुसहायक साधन और सेवाएँभी निः श उपल 800-378-5234 (TTY : 711) पर कॉल करेंयाअपनेप्रदाता सेबात करें ।

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

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

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

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

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

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

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

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

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