network health

2020

YOUR HOMETOWN™ ADVANTAGE

NetworkCares PPO SNP Summary of Benefits

2020 NETWORK*CARES* SUMMARY OF BENEFITS

SERVICE AREA AND ELIGIBILITY

To be eligible to join Network Health's PPO SNP plan described in this booklet, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, enrolled in Wisconsin Medicaid, live in the service area and not be diagnosed with end-stage renal disease (ESRD). This Summary of Benefits applies to plans offered in the following counties in Wisconsin—Brown, Calumet, Dodge, Fond du Lac, Green Lake, Kewaunee, Manitowoc, 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 Network*Cares* (PPO SNP) plan. It doesn't list every service we cover or list 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 customer service for a printed copy.

WHAT IS A SPECIAL NEEDS PLAN (PPO 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 Health Care Concierge Customer Service – 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 business office hours are Monday–Friday, 8 a.m to 5 p.m. · Network Health is closed on major holidays. · From October 1–March 31, you can call customer service seven days a week from 8 a.m. to 8 p.m., Central Time. From April 1–September 30, Monday–Friday, from 8 a.m. to 8 p.m., Central Time. · From October 1–December 31, you can call our sales department Monday–Friday from 8 a.m. to 6 p.m., and Saturdays from 8 a.m. to noon. Central Time. From January 1–September 30, Monday–Friday, from 8 a.m. to 5 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 www.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.

2020 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (PPO SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified)	
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 2019 the amounts were: $0-$185 depending on your level of Medicaid eligibility These amounts may change for 2020.	
Annual Maximum Out-of-Pocket	$6,700 for services you receive from in-network providers $10,000 for services you receive from any provider, your limit for services received from in-network providers will count towards this limit	
INPATIENT HOSPITAL COVERAGE[1]		
Inpatient Hospital[1] Per admission.	Annual Medical Deductible $0-$1,364 In 2019 the amounts were: $0 per day, Days 1-60 $341 per day, Days 61-90 $682 per day, Days 91 and beyond (this plan covers 60 lifetime reserve days) These amounts may change for 2020.	Covered
OUTPATIENT HOSPITAL COVERAGE[1]		
Outpatient Surgery Services Including Ambulatory Surgical Center Services such as colonoscopies.	0%-20% of the cost	Covered
DOCTOR VISITS		
Primary Care Provider	0%-20% of the cost	Covered
Specialist	0%-20% of the cost	
MDLIVE® Virtual Doctor Visits	$0	Not covered
PREVENTIVE CARE		
Annual Medicare Wellness Visit	$0 in-network 0%-20% of the cost out-of-network	Covered
Medicare Covered Preventive Care	$0 in-network 0%-20% of the cost out-of-network	
Medicare Covered Immunizations Flu, Pneumonia, Hepatitis B	$0 in-network 0%-20% of the cost out-of-network	Covered
EMERGENCY CARE		
Emergency Room Your cost is waived if admitted to a U.S. hospital within 24 hours.	0%-20% of the cost, up to $90	Coverage may be available outside the State of Wisconsin

Services with a 1 may require prior authorization.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

2020 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (PPO SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified)	
EMERGENCY CARE		
International Emergency Coverage View the evidence of coverage for details at networkhealth.com/medicare/plan-materials for more information.	$90 per incident $100,000 Maximum Benefit	Not covered
URGENT CARE		
Urgent Care	0%-20% of the cost, up to $65	Covered
DIAGNOSTIC IMAGING		
Ultrasound,EKG,EEG,Stress Test	0%-20% of the cost	Covered
X-rays	0%-20% of the cost	
Radiation Therapy[1] Per service.	0%-20% of the cost	
Diagnostic Radiology Services[1] Such as MRIs, CT Scans.	0%-20% of the cost	
Lab and Clinical Diagnostic Tests Genetic/molecular testing requires authorization[1]	0%-20% of the cost	Covered
HEARING		
Medicare Covered Exam	0%-20% of the cost	Covered
Routine Hearing Exam	Not covered	
Hearing Aid Discount Program Includes a one-year warranty, three office visits, one pack of batteries and one year of loss and damage insurance. Maximum of two hearing aids per year. Visit networkhealth.com/medicare/additional-benefits for more information.	Select hearing aids discounted to $1,220-$1,985 per device. Save $775-$1,215 per hearing aid.	Not covered
DENTAL		
Medicare Covered Dental Exam Does not include services in connection with care, treatment, filling, removal or replacement of teeth.	0%-20% of the cost	Covered

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2020 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (PPO SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified)	
DENTAL		
Additional dental benefits Visit networkhealth.com/medicare/additional-benefits for more information.	$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%-50% of the cost for major services (endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery, other services) $3,000 Annual Maximum	Covered
VISION		
Medicare Covered Eye Exam	0%-20% of the cost	Covered
Medicare Covered Eyewear	0%-20% of the cost	
Routine Eye Exam One exam per year with an EyeMed provider. Visit networkhealth.com/medicare/additional-benefits for more information.	$0 in-network, or $40 reimbursement out-of-network	
Non-Medicare Covered Eyewear Discounts offered at EyeMed providers. Visit networkhealth.com/medicare/additional-benefits for more information.	$400 allowance in-network, or $400 reimbursement out-of-network	
MENTAL HEALTH CARE		
Outpatient Individual or Group Therapy, Psychiatric, Telehealth	0%-20% of the cost	Covered
Inpatient Mental Health[1]	Annual Medical Deductible $0-$1,364 In 2019 the amounts were: $0 per day, Days 1-60 $0-$341 per day, Days 61-90 $0-$682 per day, Days 91 and beyond (this plan covers 60 lifetime reserve days) These amounts may change for 2020.	
SKILLED NURSING FACILITY		
Skilled Nursing Facility[1] Per admission.	In 2019 the amounts were: $0 per day, Days 1-20 $0-$170.50 per day, Days 21-100 A prior three-day inpatient hospital stay is required. These amounts may change for 2020.	Covered

Services with a 1 may require prior authorization.
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2020 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (PPO SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified)	
PHYSICAL AND OTHER OUTPATIENT THERAPY		
Physical, Occupational, Speech Therapy Includes comprehensive outpatient rehabilitation facility.	0%-20% of the cost	Covered
Cardiac and Pulmonary Rehab Maximum of 36 visits per year.	0%-20% of the cost	Covered
AMBULANCE		
Ambulance	0%-20% of the cost	Covered
TRANSPORTATION		
Non-Emergency Transportation	12 one-way trips, anywhere within the Network Health Medicare Plan service area	Covered
PRESCRIPTION DRUG BENEFITS		
Medicare Part B Drugs and Chemotherapy[1]	0%-20% of the cost	Covered
Medicare Part D Drugs	Covered - See prescription chart pages 7-9	Covered
Opioid Treatment Services	0%-20% of the cost	Covered
DURABLE MEDICAL EQUIPMENT[1]		
Insulin Pumps[1], CPAP machines, Prosthetic Devices[1]	0%-20% of the cost	Covered
DIABETES SUPPLIES AND SERVICES[1]		
Monitoring Supplies and Test Strips One Touch™ and Accu-Chek™ All other brands are not covered.	0%-20% of the cost	Covered – One Touch Not covered – Accu-Chek
Diabetic Shoe Inserts	0%-20% of the cost	Covered
Self-Monitoring Training		
Dialysis For end stage renal disease		

Services with a 1 may require prior authorization.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

2020 NETWORK*CARES* SUMMARY OF BENEFITS

	Network*Cares* (PPO SNP)	Medicaid
	YOUR COSTS, IN- AND OUT-OF-NETWORK (unless specified)	
CHIROPRACTOR		
Manipulation of the spine to correct when one or more of the bones of your spine move out of position.	0%-20% of the cost	Covered
HOME HEALTH		
Medicare Covered Home Health Care Visits[1]	$0	Covered
HOSPICE		
Hospice covered by Medicare	$0	Covered
EXTRAS		
SilverSneakers® Fitness	Included	Not covered
Caregiver Support	Included	
Over-the-Counter Coverage	$150 per year	Covered
Meal Delivery	14 meals following a qualified inpatient hospital stay	Not covered
Wellness Rewards	Earn up to $75 in gift cards by completing your annual health risk assessment, annual wellness visit and flu shot.	
Bathroom Adaptation	With proper documentation, which includes a completed Network*Cares* Bathroom Adaptation Reimbursement Form and attached itemized receipts and invoices detailing the cost of the bathroom adaptation services/items purchased, the plan will reimburse the paid amount or up to the maximum benefit of $300 each year for approved bathroom home adaptation services/items.	Not covered

Services with a 1 may require prior authorization.
Because covered services and copayments could change, you should ask your provider what your copayment amount will be. If you get more than one service during the same appointment, you may be asked for more than one copayment.

PRESCRIPTION DRUG BENEFITS

Your Drug Costs	Network*Cares* (PPO SNP)	Medicaid
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: · In- and out-of-network: 0%-20% of the cost Other Part B drugs[1]: · In- and out-of-network: 0%-20% of the cost Part D Prescription Drug Deductible on Tier 1 $0, Tiers 2-5: $420	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs

2020 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE PREFERRED RETAIL COST-SHARING

After you reach your yearly deductible of $0-$420 for your Tier 2-5 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.

Tier	One-month supply For generic drugs (including brand drugs treated as generic), either:	Three-month supply For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	· $0 copayment; or · $1.30 copayment; or ·$3.60 copayment; or lesser of $4 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or ·$3.60 copayment; or lesser of $10 or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment; or lesser of $9 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment; or lesser of $23 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $42 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	· $0 copayment; or · $1.30 copayment; or ·$3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $94 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or ·$3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $235 or 15% of the cost
Tier 5 (Specialty)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

2020 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE STANDARD RETAIL COST-SHARING

After you reach your yearly deductible of $0-$420 for your Tier 2-5 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.

Tier	One-month supply For generic drugs (including brand drugs treated as generic), either:	Three-month supply For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	· $0 copayment; or · $1.30 copayment; or ·$3.60 copayment; or lesser of $6 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or ·$3.60 copayment; or lesser of $15; or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment; or lesser of $15 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment; or lesser of $38 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $47 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $118 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $100 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $250 or 15% of the cost
Tier 5 (Specialty)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

2020 NETWORK*CARES* SUMMARY OF BENEFITS

Your Drug Costs

INITIAL COVERAGE MAIL ORDER RETAIL COST-SHARING

After you reach your yearly deductible of $0-$420 for your Tier 2-5 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.

Tier	One-month supply For generic drugs (including brand drugs treated as generic), either:	Three-month supply For generic drugs (including brand drugs treated as generic), either:
Tier 1 (Preferred Generics)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment lesser of $4 or 15% of the cost	· $0 copayment for 31-90 day mail order
Tier 2 (Generics and Non-Preferred Generics)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment lesser of $9 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment lesser of $23 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $42 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copaymentt For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $94 or 15% of the cost	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of $235 or 15% of the cost
Tier 5 (Specialty)	· $0 copayment; or · $1.30 copayment; or · $3.60 copayment For all other drugs, either: · $0 copayment; or · $3.90 copayment; or · $8.95 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

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 customer service as you may pay more than you pay at an in-network pharmacy.

2020 NETWORK*CARES* SUMMARY OF BENEFITS

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,350, you pay $0-$3.60 for drugs treated as generic and $0-$8.95 for drugs treated as brand.

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 customer service 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, 8 a.m. to 8 p.m.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit **networkhealth.com** 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 medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

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/co-insurance may change on January 1, 2021.
- ☐ 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 situations, non-contracted providers may deny care.

REQUIRED INFORMATION - Nondiscrimination

Network Health complies with applicable Federal civil rights laws, conscience and anti-discrimination laws and prohibiting exclusion, adverse treatment, coercion or other discrimination against individuals or entities on the basis of their religious beliefs or moral convictions and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. You may have the right under federal law to decline to undergo certain health care-related treatments, research, or services that violate your conscience, religious beliefs, or moral convictions.

Network Health:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Network Health's discrimination complaints coordinator at 800-378-5234 (TTY 800-947-3529).

If you believe that Network Health has failed to provide these services, has failed to accommodate your conscientious, religious or moral objection 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's discrimination complaints coordinator, 1570 Midway Place, Menasha, WI 54952, phone number 800-378-5234, TTY 800-947-3529, Fax 920-720-1907, 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 discrimination complaints coordinator 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Multi-language Interpreter Services

If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-378-5234 (TTY 800-947-3529).

Albanian: Nëse ju, ose dikush që po ndihmoni, ka pyetje për Network Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 800-378-5234 (TTY 800-947-3529).

Arabic:
إذا كان لديك أو لدى شخص كنت مساعدة، أسئلة حول Health Network، لديك الحق في الحصول على المساعدة والمعلومات باللغة الخاصة بك دون أي تكلفة. للتحدث مع مترجم فوري، قم باستدعاء 800-378-5234 (TTY 800-947-3529).

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Network Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入数字 800-378-5234 (TTY 800-947-3529).

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Network Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-378-5234 (TTY 800-947-3529).

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Network Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-378-5234 (TTY 800-947-3529) an.

Hindi: यदि आप, या किसी को आप की मदद कर रहे हैं, के बारे में सवाल है Network Health, आप कोई भी कीमत पर अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिया के लिए बात करने के लिए, 800-378-5234 (TTY 800-947-3529) कहते हैं।.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-378-5234 (TTY 800-947-3529).

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Network Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-378-5234 (TTY 800-947-3529).로 전화하십시오.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມຄໍາຖາມກ່ຽວກັບ Network Health, ທ່ານມ ສິດທ່ ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 800-378-5234 (TTY 800-947-3529).

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Network Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800-378-5234 (TTY 800-947-3529) uffrufe.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Network Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800-378-5234 (TTY 800-947-3529).

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Network Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-378-5234 (TTY 800-947-3529).

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-378-5234 (TTY 800-947-3529).

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Network Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-378-5234 (TTY 800-947-3529).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Network Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-378-5234 (TTY 800-947-3529).

800-983-7587 (TTY 800-947-3529)
networkhealth.com

Network*Cares* is a PPO 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. This plan is available to anyone who has both Medical Assistance from the State and Medicare. Out-of-network/non-contracted providers are under no obligation to treat Network Health members, except in emergency situations. Please call our customer service 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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