

2019

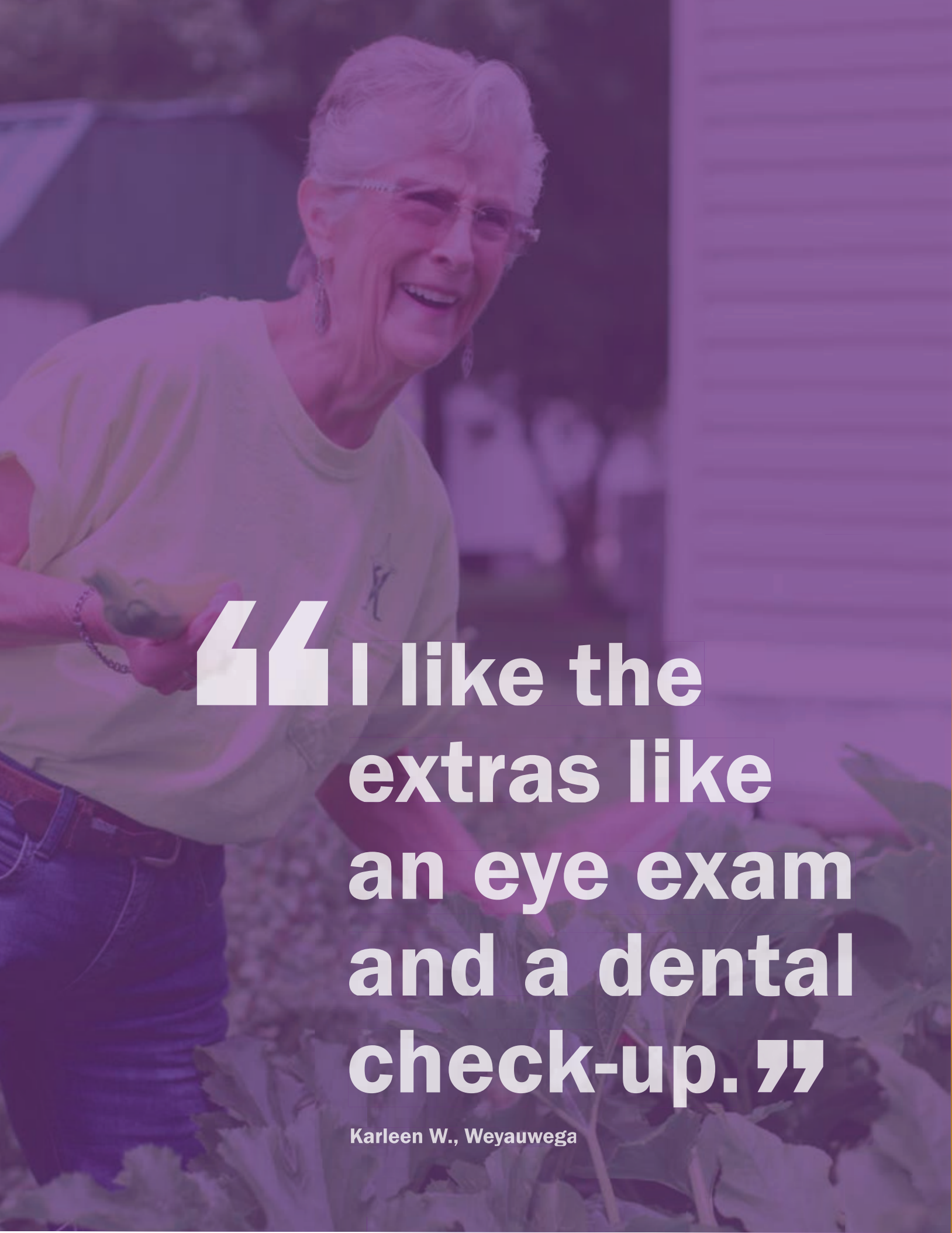
NetworkCares PPO SNP Summary of Benefits



you'll
notice the
difference



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



**“I like the
extras like
an eye exam
and a dental
check-up.”**

Karleen W., Weyauwega

2019 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?

A Summary of Benefits is a summary document that describes Network Health's Medicare Advantage Plans. In this section, you will find information on NetworkCares (PPO SNP).

A complete list of services can be found in the plan-specific Evidence of Coverage. The Evidence of Coverage for each plan is available at **networkhealth.com**. 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).

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 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 us seven days a week from 8 a.m. to 8 p.m., Central Time. • From April 1–September 30, you can call us Monday–Friday, from 8 a.m. to 8 p.m., Central Time.
Additional Resources	Medicare – Available 24 hours a day, seven days a week If you want to learn more about the coverage and costs of Original Medicare, use your current “Medicare & You” handbook, available from Medicare. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, seven days a week.

	Network <i>Cares</i> (PPO SNP)	Medicaid
PLAN COSTS		
Premium	\$0 per month. In addition, you must keep paying your Medicare Part B premium.	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.
Deductible	This plan has deductibles for some hospital and medical services. \$0–\$1,340 per year for inpatient hospital services and \$0–\$183 from in-network and out-of-network providers, depending on your level of Medicaid eligibility. These amounts may change for 2019. \$0–\$400 per year for Part D prescription drugs.	
Maximum Out-of-Pocket	Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. In this plan, you may pay nothing for some services, depending on your level of Wisconsin Medicaid eligibility. Your yearly limit(s) in this plan: \$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 toward this limit. If you reach the limit on out-of-pocket costs, you may continue getting your covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain benefits from any provider. Contact us for services that apply.	
Note: 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.		

INPATIENT HOSPITAL COVERAGE¹

The copayments for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

- In- and out-of-network: In 2018 the amounts for each benefit period were:
- \$0 - \$1,340 deductible
- \$0 copayment for days 1 through 60
- \$335 copayment per day for days 61 through 90
- \$670 copayment per day for 60 lifetime reserve days

These amounts may change for 2019.

Full coverage
\$3 copayment per day with a
\$75 cap per stay

OUTPATIENT HOSPITAL COVERAGE¹**Outpatient
Surgery Services**

Ambulatory surgical center:
• In- and out-of-network: 0% - 20% of the cost

Outpatient hospital:
• In- and out-of-network: 0% - 20% of the cost

Full coverage
\$3 copayment per visit

DOCTOR VISITS**Primary Care
Provider**

- In- and out-of-network: 0% - 20% of the cost

Full coverage
\$0.50 to \$3 copayment per
service

Specialist

- In- and out-of-network: 0% - 20% of the cost

Note: 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.

PREVENTIVE CARE

	• In-network: 0% of the cost • Out-of-network: 0% - 20% of the cost of the cost Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy) Depression screening Diabetes screenings HIV screening Medical nutrition therapy services Medicare Diabetes Prevention Program (MDPP) Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including flu shots, hepatitis B shots, pneumococcal shots “Welcome to Medicare” preventive visit (one-time) Yearly “Wellness” visit Emergency care received in the United States and its territories Urgently needed care received inside the United States and its territories Any additional preventive services approved by Medicare during the contract year will be covered. Annual physical exam: • In-network: \$0 copayment • Out-of-network: 0% - 20% of the cost	Full coverage
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EMERGENCY CARE

Emergency Room	• In- and out-of-network: 0% - 20% of the cost (up to \$90) If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.	Full coverage
Urgent Care	Urgent Care Walk-In Clinic: • In- and out-of-network: 0% - 20% of the cost	Full coverage, including laboratory and radiology \$0.50 to \$3 copayment per service, limited to \$30 per provider per calendar year. No copayment for preventive services, emergency services, anesthesia or clozapine management.

Note: 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.

	Network <i>Cares</i> (PPO SNP)	Medicaid
DIAGNOSTIC SERVICES/LABS/IMAGING		
Lab and Clinical Diagnostic Tests	In- and out-of-network: 0% - 20% of the cost	Full coverage
Outpatient X-rays	In- and out-of-network: 0% - 20% of the cost	
Ultrasound, EKGs, EEGs, Stress Test	In- and out-of-network: 0% - 20% of the cost	
Radiation Therapy	Therapeutic radiology services (such as radiation treatment for cancer): In- and out-of-network: 0% - 20% of the cost	
Diagnostic Radiology Services (Such as MRIs, CT Scans)	In- and out-of-network: 0% - 20% of the cost	
HEARING SERVICES		
Medicare Covered Exams	Exam to diagnose and treat hearing and balance issues: In- and out-of-network: 0% - 20% of the cost A hearing aid discount is offered with Simpli Hearing, LLC to NetworkCares members. Call Network Health for more information.	Full coverage \$.50 to \$3 copayment per procedure No copayment for hearing aid batteries
Note: 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.		

NetworkCares (PPO SNP)		Medicaid
DENTAL SERVICES ¹		
Medicare Covered Dental	Visit medicareadvantage.deltadentalwi.com for a list of in-network dentists. Limited dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth): • In- and out-of-network: 0% - 20% of the cost Preventive dental services: Cleaning (twice a year): • In- and out-of-network: \$0 copayment Dental x-ray(s) (bitewing 1 per year, full mouth 1 every 5 years): • In- and out-of-network: \$0 copayment Oral exam (twice a year): • In- and out-of-network: \$0 copayment Basic Restorative Services: • In- and out-of-network: 0% of the cost Major Services (endodontics/periodontics/extractions, prosthodontics, other oral/maxillofacial surgery, other services): • In- and out-of-network: 0% - 50% of the cost Our plan pays up to \$3,000 every year for most dental services.	Full coverage \$.50 to \$3 copayment per service
Supplemental Dental	Not covered	
VISION SERVICES		
Medicare Covered Exams	Visit eyemedvisioncare.com for a list in-network providers. Select the Insight network. Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In- and out-of-network: 0% - 20% of the cost Routine eye exam (for up to 1 every year): • In-network: \$0 • Out-of-network: Eye Med will reimburse up to \$30 Eyeglasses or contact lenses after cataract surgery: • In- and out-of-network: 0% - 20% of the cost Our plan pays up to \$500 in-network or \$400 out-of-network annually for contact lenses and/or glasses with a valid prescription, including enhancements.	Routine Vision - full coverage including coverage of eyeglasses. \$0.50 to \$3 copayment per service
Note: 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.		

MENTAL HEALTH CARE**Inpatient**

Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit applies to inpatient mental services provided in a general hospital.

The copayments for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan covers 90 days for an inpatient hospital stay.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days up to a total 190 lifetime days.

- In- and out-of-network: In 2018 the amounts for each benefit period were:

- \$0 - \$1,340 deductible
- \$0 copayment for days 1 - 60
- \$0 - \$335 copayment per day for days 61 through 90
- \$0 - \$670 copayment per day for 60 lifetime reserve days

These amounts may change for 2019.

Full coverage (not including room and board)
\$.50 to \$3 copayment per service, limited to the first 15 hours or \$825 of services, whichever comes first, provided per calendar year. Copayment is not required when services are provided in a hospital setting.

Outpatient

These amounts may change for 2019.

Outpatient group therapy visit:

- In- and out-of-network: 0% - 20% of the cost

Outpatient individual therapy visit:

- In- and out-of-network: 0% - 20% of the cost

SKILLED NURSING FACILITY¹

Our plan covers up to 100 days in a SNF.

- In- and out-of-network: In 2018 the amounts for each benefit period were:

- \$0 copayment for days 1 through 20
- \$0 - \$167.50 copayment per day for days 21 through 100

These amounts may change for 2019. A prior three-day inpatient hospital stay is required.

Full coverage
No copayment

Note: 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.

	Network <i>Cares</i> (PPO SNP)	Medicaid
PHYSICAL THERAPY		
	• In- and out-of-network: 0% - 20% of the cost	
AMBULANCE		
	• In- and out-of-network: 0% - 20% of the cost	Full coverage of emergency transportation to and from a certified provider for a covered service.
TRANSPORTATION		
	Not covered	
PRESCRIPTION DRUG BENEFITS		
Medicare Part B Drugs and Chemotherapy ¹	• In- and out-of-network: 0% - 20% of the cost	
Medicare Part D Drugs	Covered	
CHIROPRACTIC CARE		
	Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In- and out-of-network: 0% - 20% of the cost	Full coverage \$.50 to \$3 copayment per service
DIABETES SUPPLIES AND SERVICES ¹		
Monitoring Supplies and Test Strips	• In- and out-of-network: 0% - 20% of the cost	Full coverage \$.50 to \$3 copayment per service and \$.50 per prescription for diabetic supplies
Self-Monitoring Training	• In- and out-of-network:: 0% - 20% of the cost	
Therapeutic Shoes/ Inserts	• In- and out-of-network: 0% - 20% of the cost	
PROSTHETIC DEVICES (BRACES, ARTIFICIAL LIMBS, ETC.) ¹		
Prosthetic Devices	• In- and out-of-network: 0% - 20% of the cost	Full coverage
Related Medical Supplies	• In- and out-of-network: 0% - 20% of the cost	
HOME HEALTH CARE ¹		
	• In- and out-of-network: \$0 copayment	Full coverage
Note: 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

How much do I pay?	For Part B drugs such as chemotherapy drugs¹: • In- and out-of-network: 0% - 20% of the cost Other Part B drugs¹: • In- and out-of-network: 0% - 20% of the cost Part D Prescription Drug Deductible on Tiers 1 - 5: \$0 - \$400	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs
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INITIAL COVERAGE PREFERRED RETAIL COST-SHARING

After you reach your yearly deductible of \$0-\$400 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 • \$1.25 copayment; or • \$3.40 copayment; or - lesser of \$4 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or - lesser of \$10 or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or - lesser of \$8 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or - lesser of \$20 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or - lesser of \$42 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or - lesser of \$105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or - lesser of \$84 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or - lesser of \$210 or 15% of the cost
Tier 5 (Specialty)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or - lesser of 15% of the cost or 25% of the cost	Not offered

NetworkCares (PPO SNP)

INITIAL COVERAGE STANDARD RETAIL COST-SHARING

After you reach your yearly deductible of \$0-\$400 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 • \$1.25 copayment; or • \$3.40 copayment; or lesser of \$6 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or lesser of \$15; or 15% of the cost
Tier 2 (Generics and Non-Preferred Generics)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or lesser of \$14 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or lesser of \$35 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$47 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$118 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$91 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$228 or 15% of the cost
Tier 5 (Specialty)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of 15% of the cost or 25% of the cost	Not offered

NetworkCares (PPO SNP)

INITIAL COVERAGE MAIL ORDER COST-SHARING

After you reach your yearly deductible of \$0-\$400 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 • \$1.25 copayment; or • \$3.40 copayment; or 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 • \$1.25 copayment; or • \$3.40 copayment; or lesser of \$8 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment; or lesser of \$20 or 15% of the cost
Tier 3 (Non-Preferred Generics and Preferred Brands)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$42 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$105 or 15% of the cost
Tier 4 (Non-Preferred Generics and Non-Preferred Brands)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$84 or 15% of the cost	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 copayment; or lesser of \$210 or 15% of the cost
Tier 5 (Specialty)	• \$0 copayment; or • \$1.25 copayment; or • \$3.40 copayment For all other drugs, either: • \$0 copayment; or • \$3.80 copayment; or • \$8.50 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.

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,100, you pay \$0-\$3.40 for generic drugs and \$0-\$8.50 for brand drugs.

REMINDERS

- If you do not add prescription drug coverage when you are first eligible (and you do not have coverage that's as good as or better than Medicare Part D coverage) and you choose to add it later, you may have to pay a penalty.
- You can only be enrolled in one Part D prescription drug plan at a time. If you are enrolled in a Medicare Advantage Plan, you must receive your Part D coverage through that plan.
- If you enroll in a Stand Alone Prescription Drug Plan, you will automatically be disenrolled from the Medicare Advantage Plan and returned to Original Medicare.

OUR PLANS HAVE FIVE DRUG TIERS	
Tier 1 – Preferred generic	Tier 1 is the lowest tier. Lower cost preferred generic drugs are included in this tier.
Tier 2 – Generic	Tier 2 includes higher cost preferred generic drugs.
Tier 3 – Preferred brand	Tier 3 includes lower cost preferred brand drugs and higher cost generic drugs.
Tier 4 – Non-preferred brand	Tier 4 includes higher cost non-preferred brand drugs and non-preferred generic drugs.
Tier 5 – Specialty drugs	Tier 5 is the highest tier. Very high cost brand and generic drugs, as well as drugs that require special handling and/or close monitoring, are included in this tier.

WHAT IS THE DIFFERENCE BETWEEN BRAND NAME AND GENERIC DRUGS?

A brand name drug is a drug that is protected by a patent. The drug can only be made or sold by the company that holds the patent. A generic drug is approved by the U.S. Food and Drug Administration (FDA) as having the same active ingredients as a brand name drug, but generally, the generic drug will cost less.

IS A GENERIC DRUG AS GOOD AS A BRAND NAME DRUG?

Yes, generic drugs are just as good as the brand name because they are approved by the FDA as meeting the same standards.

HOW TO LOOK UP PRESCRIPTION DRUGS AND PHARMACIES

WHERE DO I FIND OUT WHAT DRUGS ARE COVERED?

Covered drugs are listed in our drug list, called the formulary. You will find an interactive search online at [networkhealth.com](https://www.networkhealth.com), simply select **Look Up Medications**.

HOW DO I KNOW WHICH PHARMACIES ARE COVERED?

You can search for pharmacies by visiting [networkhealth.com](https://www.networkhealth.com), select **Find a Pharmacy**. Our pharmacy directory lists in-network pharmacies for your prescriptions. You must use one of these pharmacies for your prescriptions to be covered. In addition, if you use a preferred pharmacy, your copayment will be lower. Preferred pharmacies are marked with an asterisk (*) in the pharmacy directory. A few of our preferred pharmacies in your neighborhood include ShopKo®, Walgreens and Pick n Save® locations. To find an in-network pharmacy while traveling, please call us at 855-653-4636 (TTY 800-947-3529), Monday–Friday, 8 a.m. to 8 p.m. From October 1–March 31, we’re available seven days a week, 8 a.m. to 8 p.m.

HOW CAN I SAVE EVEN MORE ON PRESCRIPTIONS?

You can save even more with a 90-day supply of your medications at a retail pharmacy or through mail order. A 90-day supply of Tier 1 medications filled through mail order is available for a \$0 copayment. Visit [Express-Scripts.com](https://www.Express-Scripts.com) to sign up for mail order, or call 855-653-4363 (TTY 800-899-2114), 24 hours a day, seven days a week.

BELOW IS A LIST OF THE TOP 10 DRUGS THAT ARE \$0 FOR 90 DAYS WITH MAIL ORDER

amlodipine	atorvastatin
furosemide	levothyroxine
lisinopril	metformin
metoprolol	omeprazole
sertraline	simvastatin



Check your prescription drug coverage at networkhealth.com, select Look Up Medications.

SUPPLEMENTAL BENEFITS

Network Health also offers the following supplemental benefits.

ADDITIONAL SUPPLEMENTAL BENEFITS

NetworkCares (PPO SNP)

SilverSneakers®

Included

TRAVEL BENEFIT

When you travel outside of Wisconsin, within the United States, your coverage goes with you. Visit any provider who accepts Medicare beneficiaries, and you'll be covered as though you're seeing an in-network provider. For international coverage, refer to your Evidence of Coverage for more information. Wisconsin Medicaid does not have coverage outside of the state of Wisconsin.

HEARING AID DISCOUNT

Through our partnership with Simpli Hearing, LLC, members will find quality brand name hearing aids discounted to \$1,220 - \$1,985. This discount program includes a one-year warranty, three office visits, one pack of batteries and one year of loss and damage insurance.

BATHROOM ADAPTATION

With proper documentation, which includes a completed NetworkCares 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.

DURABLE MEDICAL EQUIPMENT¹

NetworkCares offers reimbursement of up to a maximum of \$170 annually for the purchase of:

- Scales (for daily weight management for members with congestive heart failure)
- Blood pressure cuffs—manual and automatic
- Pill boxes and medi planners
- Sharps containers
- Shower benches/tub chairs

Note: 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.

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 **800-378-5234** (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

- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2020.
- ☐ 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.
- ☐ 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.



**“Network
Health is the
best value on
the market,
without
question.”**

Nondiscrimination

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. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o 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 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).

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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 [在此插入數字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 위해서는 800-378-5234 (TTY 800-947-3529) 로 전화하십시오.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບ Network Health, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກກັບນາຍພາສາ, ໃຫ້ໂທຫາ 800-378-5234 (TTY 800-947-3529).

Pennsylvania Dutch: Wann du hoscht en Froog, odder ebber, wu du helpscht, 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).

Notes

Notes



**“I don’t have
any trouble
seeing my
doctors.”**

Betty C., Appleton



800-983-7587 (TTY 800-947-3529)
[networkhealth.com](https://www.networkhealth.com)

NetworkCares 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. This information is not a complete description of benefits. Call 800-378-5234 (TTY 800-947-3529) for more information. 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. H5215_1822-01d-0818_M Accepted 10232018