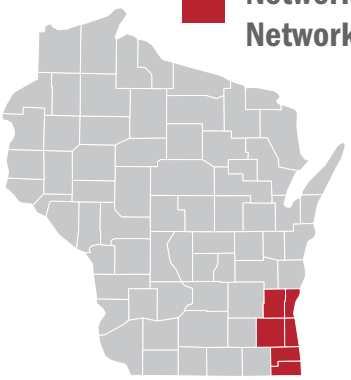
2025

Southeast Wisconsin

Medicare Advantage PPO Plans

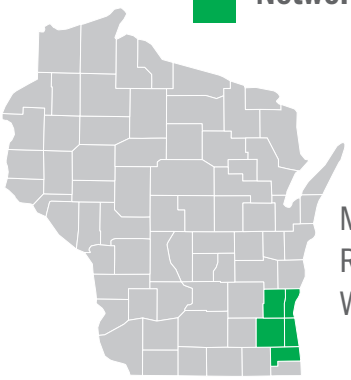
Plans at a Glance

Network Health Anywhere
Network Health Bravo



Kenosha, Milwaukee, Ozaukee, Racine, Washington, Waukesha

Network Health Go



Milwaukee, Ozaukee, Racine, Washington, Waukesha

network health

BENEFITS AT A GLANCE

Your Costs	Network Health Go (PPO) (Includes pharmacy) Refer to county listing on front cover In-Network	Out-of-Network	Network Health Anywhere (PPO) (Includes pharmacy) YOU PAY THE SAME IN- AND OUT-OF-NETWORK FOR MEDICAL BENEFITS	
Monthly Premium	$0		$0	
Monthly Part B Premium Giveback[2] Must be enrolled in Medicare Parts A and B, pay own premiums and live in a service area that offers this benefit	Not included		$26 per month	
Annual Maximum Out-of-Pocket (Does not include Part D prescription drugs)	$3,900	$6,200 combined in- and out-of-network	$3,800 combined in- and out-of-network	
Inpatient Hospital Services[1] Per admission	$295 per day, days 1 - 6 $0 days 7 and beyond	$800 per day, days 1 - 7 $0 days 8 and beyond	$275 per day, days 1 - 6 $0 days 7 and beyond	
Outpatient Hospital Services[1]	$0 to $275	$0 to $550	$0 to $260	
Ambulatory Surgical Center[1]	$0 to $225	$0 to $450	$0 to $185	
Primary Care Provider Visit	$0	$30	$0	
Specialist Visit	$50	$100	$35	
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	$125	$125	$125	
Urgent Care Visit Free-standing facility	$50	$50	$35	
Diagnostic Tests[1] Such as ultrasound, EKG, stress test	$35	$70	$90	
Labs– What you pay may be based on the service received and/or where you are treated	$0 to $20	$40	$0 to $40	
Diagnostic Radiology Services[1] Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	$275	$550	$310	
X-rays	$35	$70	$90	
Routine Hearing Exam[2]	$0	$40	$0	$40
Dental Services[2]	Up to $1,200 reimbursed through Pick Your Perks		100% preventive, 50% comprehensive coverage in-network, $2,000 combined in- and out-of-network annual maximum Member pays 80% out-of-network	
Annual Routine Vision Exam[2]	$10	$40 reimbursement	$0	$40 reimbursement out-of-network
Additional Eyewear[2]	Up to $1,200 reimbursed through Pick Your Perks		$350 allowance at EyeMed providers	
Outpatient Physical[1]**, Occupational**[1]**, Speech Therapy**	$50	$100	$35	
Air and Ground Ambulance Services	$275	$275	$250	
Pick Your Perks[2]*	$1,200		Not available	
Over-the-Counter Catalog[2]	Up to $1,200 reimbursed through Pick Your Perks		Not available	

BENEFITS AT A GLANCE

Network Health Bravo (PPO) (Excludes pharmacy)

Refer to county listing on front cover

Your Costs	In-Network	Out-of-Network
Monthly Premium	$0	
Monthly Part B Premium Giveback[2] Must be enrolled in Medicare Parts A and B, pay own premiums and live in a service area that offers this benefit	Not included	
Annual Maximum Out-of-Pocket (Does not include Part D prescription drugs)	$4,500	$8,000 combined in- and out-of-network
Inpatient Hospital Services[1] Per admission	$295 per day, days 1 - 6 $0 days 7 and beyond	$550 per day, days 1 - 6 $0 days 7 and beyond
Outpatient Hospital Services[1]	$0 to $275	$0 to $450
Ambulatory Surgical Center[1]	$0 to $225	$0 to $450
Primary Care Provider Visit	$0	$30
Specialist Visit	$40	$75
Emergency Room Visit Copayment is waived if admitted to a U.S. hospital within 24 hours	$125	$125
Urgent Care Visit Free-standing facility	$45	$45
Diagnostic Tests[1] Such as ultrasound, EKG, stress test	$20	$50
Labs What you pay may be based on the service received and/or where you are treated	$0 to $20	$30
Diagnostic Radiology Services[1] Advanced Imaging (PET, CAT, MRI, MRA, NUC Scans)	$200	$250
X-rays	$35	$40
Routine Hearing Exam[2]	$0	$40
Dental Services[2]	100% coverage in-network, Includes one implant and resin $5,000 combined in- and out-of-network annual maximum	Member pays 50% out-of-network
Annual Routine Vision Exam[2]	$0	$40 reimbursement
Additional Eyewear[2]	$400 allowance at EyeMed providers	Not covered
Outpatient Physical[1]**, Occupational**[1]**, Speech Therapy**	$30	$75
Air and Ground Ambulance Services	$300	$300
Pick Your Perks[2]*	Not available	Not available
Over-the-Counter Catalog[2]	$100 per quarter Two orders per quarter, No rollover on quarterly allowance	Not available

[1]Service may require prior authorization.

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

*Reimbursement for the following extra benefits: dental services, vision hardware, healthy home-delivered meals, non-emergency transportation, over-the-counter items, acupuncture, massage therapy, personal training (4 visits or $225 allowance), nutritional/dietary counseling

BENEFITS ON ALL PLANS

Hearing Aids[2], Maximum of two hearing aids per year. Hearing aid evaluation and purchase through TruHearing, fitting included. In-network $495-$1,695 per device. No coverage out-of-network.

Fitness Benefit with One Pass™ [2]

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.

YOUR DRUG COSTS		Network Health Go (PPO)	Network Health Anywhere (PPO)
		Refer to county listing on front cover	
Annual Drug Deductible		$320 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** **Preferred Pharmacy or** **Preferred Mail Order Pharmacy**	$2 for Tier 1 $8 for Tier 2 24% for Tier 3 37% for Tier 4 29% for Tier 5	$2 for Tier 1 $8 for Tier 2 23% for Tier 3 37% for Tier 4 29% for Tier 5
PREFERRED	**3-Month Supply** **Preferred Pharmacy** **100-Day Supply for Tier 1** **90-Day Supply for Tiers 2-4**	$5 for Tier 1 $20 for Tier 2 24% for Tier 3 37% for Tier 4 Tier 5 not available	$5 for Tier 1 $20 for Tier 2 23% for Tier 3 37% for Tier 4 Tier 5 not available
PREFERRED	**31 to 100-Day Supply Preferred Mail Order Pharmacy** **100-Day Supply for Tier 1 –** $0 **90-Day Supply for Tier 2 –** $0 after deductible		
PREFERRED	**3-Month Supply** **Preferred Mail Order Pharmacy** **100-Day Supply for Tier 1** **90-Day Supply for Tiers 2-4**	$0 for Tier 1 $0 for Tier 2 after deductible 24% for Tier 3 37% for Tier 4 Tier 5 not available	$0 for Tier 1 $0 for Tier 2 after deductible 23% for Tier 3 37% for Tier 4 Tier 5 not available
Part D Insulin–One-month supply **$35**			
Part D Vaccines–Shingrix, Tdap, all other adult ACIP recommended vaccines **$0**			
CATASTROPHIC COVERAGE			
You enter catastrophic coverage when your total out-of-pocket costs reach $2,000. You pay $0.			

Call a Network Health Advisor

network health

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

We're available Monday–Friday, 8 a.m. to 8 p.m.
From October 1–March 31, we're available to assist you seven days a week, 8 a.m. to 8 p.m.

Network Health Medicare Advantage Plans include PPO plans with a Medicare contract. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal. Out-of-network/noncontracted providers are under no obligation to treat Network Health members, except in emergency situations. Please call our member experience number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. H5215_**4619**-02-0824_M