



**Southeast Wisconsin  
Medicare  
Advantage PPO  
Summary of  
Benefits**

**2021**

**Medicare Advantage Plans**

**GOING ABOVE AND BEYOND**



*Locally owned by*



Ascension

# 2021 PPO SUMMARY OF BENEFITS

## SERVICE AREA AND ELIGIBILITY

To be eligible to join Network Health's Medicare Advantage 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 plans offered in the following counties in Wisconsin—Milwaukee, Ozaukee, Racine, Washington and Waukesha.

## WHAT IS A SUMMARY OF BENEFITS?

This booklet gives you a summary of what we cover and what you pay. 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](https://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.

## CONTACT NETWORK HEALTH

<b>By Phone</b>	Sales Department – <b>800-983-7587</b> Member Experience Team – <b>800-378-5234</b> TTY/TDD Users – <b>800-947-3529</b>	
<b>Online</b>	<b>networkhealth.com</b>	
<b>By Mail or In Person</b>	Network Health 1570 Midway Pl. Menasha, WI 54952	Network Health 16960 W. Greenfield Avenue Suite 5 Brookfield, WI 53005
<b>Hours of Operation</b>	<ul style="list-style-type: none"><li>• Normal office hours are Monday–Friday, 8 a.m. to 5 p.m.</li><li>• 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.</li><li>• From October 1–March 31, you can call the sales department and the member experience team seven days a week from 8 a.m. to 8 p.m., Central Time. From April 1–September 30, we are available Monday–Friday, from 8 a.m. to 8 p.m., Central Time.</li></ul>	
<b>Additional Resources</b>	<b>Medicare – Available 24 hours a day, seven days a week</b> For coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at <a href="https://www.medicare.gov">medicare.gov</a> 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.	

# 2021 PPO SUMMARY OF BENEFITS

## PPO PLANS WITH PHARMACY COVERAGE

Your Costs	Network Health Medicare Go (Includes pharmacy) (PPO)		Network Health Medicare Anywhere (Includes pharmacy) (PPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Premium	\$0		\$35	
Annual Medical Deductible	\$0		\$0	
Annual Maximum Out-of-Pocket (Does not include prescription drugs)	\$4,900	\$5,900 combined in- and out-of-network	\$4,500	\$6,900 combined in- and out-of-network
Inpatient Hospital <sup>1</sup> Per admission	\$335 per day, Days 1 - 5 \$0 Days 6 and beyond	\$550 per day, Days 1 - 6 \$0 Days 7 and beyond	\$265 per day, Days 1 - 6 \$0 Days 7 and beyond	\$550 per day, Days 1 - 6 \$0 Days 7 and beyond
Outpatient Surgery Services	\$385	\$450	\$285	\$415
Ambulatory Surgical Center Services Such as diagnostic colonoscopies	\$385	\$450	\$285	\$415
Primary Care Provider Visit	\$0	\$30	\$0	\$25
Specialist Visit	\$35	\$75	\$35	\$75
Virtual Visit Virtual visit for medical (including dermatology) and behavioral health through MDLIVE <sup>®2</sup>	\$0	\$0	\$0	\$0
Preventive Annual Medicare Wellness Visit	\$0	\$15	\$0	\$25

<sup>1</sup>Service may require prior authorization.

<sup>2</sup>Visit [networkhealth.com/medicare/additional-benefits](https://networkhealth.com/medicare/additional-benefits) for more information.

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	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Preventive Care*</b>	\$0	\$15	\$0	\$25
<b>Preventive Medicare-Covered Vaccines</b> Such as flu and pneumonia	\$0	\$0	\$0	\$0
<b>Emergency Room Visit</b> Copayment is waived if admitted to a U.S. hospital within 24 hours	\$90	\$90	\$90	\$90
<b>International Emergency Coverage</b> View the <i>Evidence of Coverage</i> at <a href="http://networkhealth.com/medicare/plan-materials">networkhealth.com/medicare/plan-materials</a> for details	\$90 per incident \$100,000 Maximum benefit	\$90 per incident \$100,000 Maximum benefit	\$90 per incident \$100,000 Maximum benefit	\$90 per incident \$100,000 Maximum benefit
<b>Urgent Care</b>	\$45	\$45	\$45	\$45
<b>Diagnostic Tests</b> Such as ultrasound, EKG, stress test	\$40	\$50	\$35	\$90
<b>X-rays</b>	\$35	\$45	\$20	\$90
<b>Diagnostic Radiology Services</b> Such as MRIs, CT scans	\$200	\$250	\$200	\$250
<b>Diagnostic Lab Tests</b>	\$0-\$20	\$30	\$0-\$20	\$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

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Your Costs	Network Health Medicare Go (Includes pharmacy) (PPO)		Network Health Medicare Anywhere (Includes pharmacy) (PPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Diagnostic Hearing Exam</b> Exam to diagnose and treat hearing issues	\$35	\$75	\$35	\$75
<b>Routine Hearing Exam</b>	Not covered	Not covered	Not covered	Not covered
<b>Hearing Aids<sup>2</sup></b> Includes a three-year warranty with loss and damage insurance, up to six hearing aid follow up visits within three years and 16 batteries. Maximum of two hearing aids per year.	Select hearing aids discounted to \$795-\$2,370 per device  (A savings of up to \$1,050 per hearing aid)	Select hearing aids discounted to \$795-\$2,370 per device  (A savings of up to \$1,050 per hearing aid)	Select hearing aids discounted to \$795-\$2,370 per device  (A savings of up to \$1,050 per hearing aid)	Select hearing aids discounted to \$795-\$2,370 per device  (A savings of up to \$1,050 per hearing aid)
<b>Medicare-Covered Dental Services</b> Does not include services in connection with care, treatment, filling, removal or replacement of teeth	\$35	\$75	\$35	\$75
<b>Preventive Dental Exam<sup>2</sup></b> One exam and cleaning per year, X-rays are not included	See Pick Your Perks Reimbursement Program	See Pick Your Perks Reimbursement Program	\$30	\$100 reimbursement out-of-network
<b>Comprehensive Dental Benefit<sup>2</sup></b>	\$38 monthly premium Annual Maximum: \$1,000	\$38 monthly premium Annual Maximum: \$1,000	\$38 monthly premium Annual Maximum: \$1,000	\$38 monthly premium Annual Maximum: \$1,000

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Your Costs	Network Health Medicare Go (Includes pharmacy) (PPO)		Network Health Medicare Anywhere (Includes pharmacy) (PPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Diagnostic Eye Exam</b> To diagnose and treat diseases and conditions of the eye	\$35	\$75	\$35	\$75
<b>Routine Eye Exam<sup>2</sup></b> One exam per year	\$10	\$40 reimbursement out-of-network	\$10	\$40 reimbursement out-of-network
<b>Post-Cataract Eyewear<sup>2</sup></b> One pair of eyeglasses or contact lenses after each cataract surgery	\$0	\$75	\$0	\$75
<b>Additional Eyewear<sup>2</sup></b> Discounts offered at EyeMed providers	See Pick Your Perks Reimbursement Program, discounts also included	See Pick Your Perks Reimbursement Program, discounts also included	Discounts included	Discounts included
<b>Outpatient Mental Health</b> Individual or group therapy	\$40	\$50	\$40	\$50
<b>Inpatient Mental Health<sup>1</sup></b> Per admission	\$395 per day, Days 1 - 4 \$0 Days 5 and beyond	\$395 per day, Days 1 - 4 \$0 Days 5 and beyond	\$295 per day, Days 1 - 4 \$0 Days 5 and beyond	\$395 per day, Days 1 - 3 \$0 Days 4 and beyond
<b>Skilled Nursing Facility<sup>1</sup></b> Per admission	\$0 per day, Days 1 - 20 \$184 per day, Days 21 - 57 \$0 Days 58 - 100	\$0 per day, Days 1 - 20 \$184 per day, Days 21 - 57 \$0 Days 58 - 100	\$0 per day, Days 1 - 20 \$184 per day, Days 21 - 49 \$0 Days 50 - 100	\$0 per day, Days 1 - 20 \$184 per day, Days 21 - 49 \$0 Days 50 - 100
<b>Physical, Occupational, Speech Outpatient Therapy</b> Includes comprehensive outpatient rehabilitation facility	\$40	\$75	\$40	\$75

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	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Ambulance - Air and Ground Services</b>	\$275	\$275	\$250	\$250
<b>Transportation - Non-Emergency</b> Includes 24 one-way trips for all members diagnosed with end stage renal disease (ERSD), to get to and from dialysis for treatment	Covered	Covered	Covered	Covered
<b>Medicare Part B Drugs and Chemotherapy<sup>1</sup></b>	20% of the cost	50% of the cost	20% of the cost	50% of the cost
<b>Medicare Part D Drugs</b> See prescription drug chart for tier information	Covered	Covered	Covered	Covered
<b>Radiation Therapy<sup>1</sup></b> Per service	20% of the cost	25% of the cost	20% of the cost	25% of the cost
<b>Chiropractic Services</b> Manipulation of the spine to correct misalignment of one or more of the bones of your spine	\$20	\$40	\$20	\$40

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	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Diabetes Monitoring Supplies and Test Strips</b> OneTouch™ and Accu-Chek™ test strips, continuous glucose monitoring supplies limited to FreeStyle Libre® and Dexcom®. All other brands are not covered.	\$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
<b>Diabetic Shoe Inserts</b> Copayment per pair	\$10	\$30	\$10	\$25
<b>Dialysis</b> Per treatment	20% of the cost	25% of the cost	20% of the cost	25% of the cost
<b>Durable Medical Equipment<sup>1</sup></b> Such as insulin pumps, CPAP machines, prosthetic devices	20% of the cost	25% of the cost	20% of the cost	25% of the cost
<b>Medicare-Covered Home Health Care Visits</b>	\$0	\$15	\$0	\$15
<b>Opioid Treatment Services</b> Counseling and therapy services provided by opioid treatment programs	\$40	\$50	\$40	\$50
<b>Substance Abuse Services</b> Outpatient individual or group therapy	\$40	\$50	\$40	\$50

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Your Costs	Network Health Medicare Go (Includes pharmacy) (PPO)		Network Health Medicare Anywhere (Includes pharmacy) (PPO)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Medicare-Covered Acupuncture</b> For chronic low back pain only, up to 12 visits in 90 days and no more than 20 visits per year	\$35	\$75	\$35	\$75
<b>Acupuncture</b> As an alternative to nausea medications, a maximum of 12 visits per year are covered for members who are undergoing chemotherapy	\$0	\$0	\$0	\$0
<b>SilverSneakers® Fitness<sup>2</sup></b>	Included	Included	Included	Included

New in 2021				
<b>Pick Your Perks Reimbursement Program<sup>2</sup></b> Reimbursement for Medicare-approved supplemental benefits including dental, vision, meals, non-emergency transportation, over-the-counter items, acupuncture, massage therapy expenses and nutritional/dietary benefits	\$775	Not included	Not included	Not included

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	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Over-the-Counter Coverage<sup>2</sup></b> No rollover on quarterly allowance	See Pick Your Perks Reimbursement Program	See Pick Your Perks Reimbursement Program	Not included	Not included
<b>Home-Based Palliative Care Consultation and Evaluation</b> One visit per year for all members diagnosed with end-stage (stage 4) cancer	\$0	\$0	\$0	\$0

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## PPO PLANS WITH PHARMACY COVERAGE

Your Drug Costs	Network Health Medicare Go (Includes pharmacy) (PPO)	Network Health Medicare Anywhere (Includes pharmacy) (PPO)
WHEN YOUR COVERAGE STARTS, YOU HAVE A \$0 DEDUCTIBLE FOR TIERS 1–3		
Drug Deductible	\$275	\$250
INITIAL COVERAGE - Amount shown is the maximum you will pay, you may pay less.		
30-Day Supply Preferred Pharmacy or Mail Order Pharmacy	\$2 for Tier 1 \$8 for Tier 2 \$42 for Tier 3 \$90 for Tier 4 28% of the cost for Tier 5	
90-Day Supply Preferred Pharmacy	\$5 for Tier 1 \$20 for Tier 2 \$105 for Tier 3 \$225 for Tier 4 Tier 5 is not available	
31 to 90-Day Supply Mail Order Pharmacy	\$0 for Tier 1	
90-Day Supply Mail Order Pharmacy	\$0 for Tier 1 \$20 for Tier 2 \$105 for Tier 3 \$225 for Tier 4 Tier 5 is not available	
30-Day Supply Standard Pharmacy	\$4 for Tier 1 \$14 for Tier 2 \$47 for Tier 3 \$100 for Tier 4 28% of the cost for Tier 5	
90-Day Supply Standard Pharmacy	\$10 for Tier 1 \$35 for Tier 2 \$118 for Tier 3 \$250 for Tier 4 Tier 5 is not available	
COVERAGE GAP		
You enter the coverage gap when your total drug costs reach \$4,130. You pay 25% and Network Health pays 75% for generic drugs.		
For brand name drugs, you pay 25%, Network Health pays 5% and the drug company pays 70%.		
CATASTROPHIC COVERAGE		
You enter catastrophic coverage when your true out-of-pocket costs reach \$6,550. You pay the greater of \$3.70 or 5% of the cost for generic drugs and \$9.20 or 5% of the cost for brand name drugs.		



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**If you have a chance to work with them, go ahead and do it. They may be able to help you save money and get yourself organized. - Ellen S.**

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# 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 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 for which you see a doctor. Visit [networkhealth.com/medicare/plan-materials](https://networkhealth.com/medicare/plan-materials) 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 medicine 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/coinsurance may change on January 1, 2022.
- ☐ 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. In addition, you will pay a higher copayment for services received by non-contracted providers.







800-983-7587 (TTY 800-947-3529)

**[networkhealth.com](https://www.networkhealth.com)**