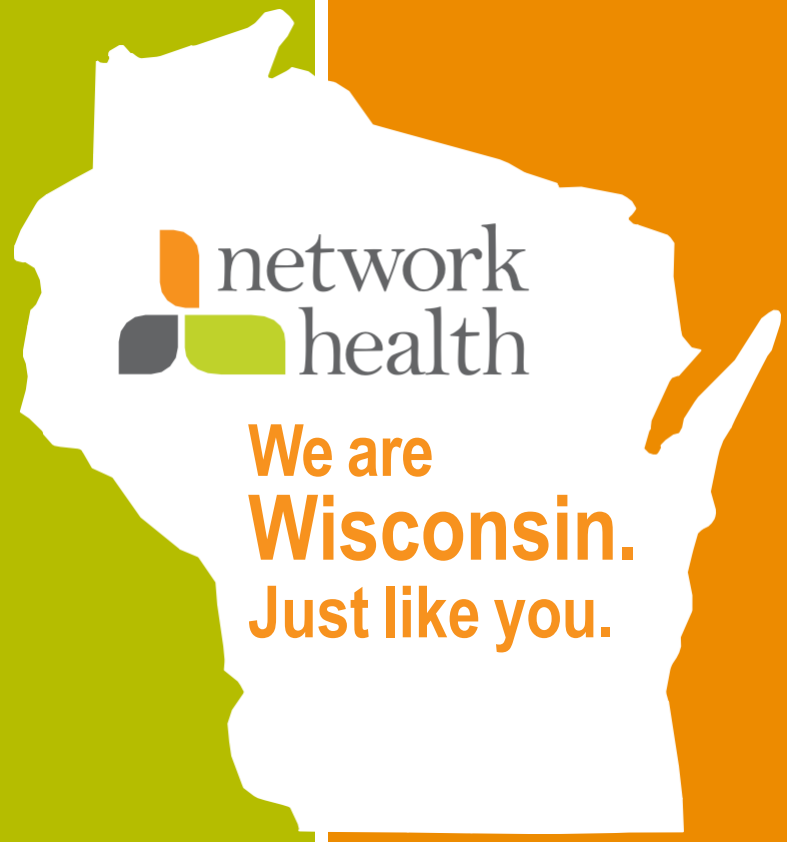

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2026 EVIDENCE OF COVERAGE

NETWORK HEALTH MEDICARE ADVANTAGE PLANS

Network Health Prime MSA

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of Network Health Prime (MSA)

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing;
- Our medical and drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us
- Other protections required by Medicare law.

For questions about this document or to order a printed copy, please contact our member experience team at 800-378-5234 (TTY users should call 711). Hours are Monday – Friday from 8 a.m. to 8 p.m. From October 1, 2025 through March 31, 2026, we are available every day, from 8 a.m. to 8 p.m. This call is free.

This plan, Network Health Prime, is offered by Network Health Insurance Corporation. (When this *Evidence of Coverage* says "we," "us," or "our," it means Network Health Insurance Corporation. When it says "plan" or "our plan," it means Network Health Prime.)

Benefits, premiums, deductibles, and/or deposit may change on January 1, 2027.

2026 Evidence of Coverage

Table of Contents

CHAPTER 1: Get started as a member

SECTION 1 You're a member of Network Health Prime

Section 1.1 You're enrolled in Network Health Prime, which is a Medicare Medical Savings Account Plan

You're covered by Medicare, and you chose to get your Medicare health care through our plan, Network Health Prime. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Network Health Prime is a Medicare Advantage Medical Savings Account (MSA) Plan. This plan doesn't include Part D drug coverage. Like all Medicare health plans, this Medicare MSA Plan is approved by Medicare and run by a private company. If you're interested in enrolling in a Medicare drug plan or want to see what plans are available in your area, visit www.Medicare.gov or call 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048. Generally, unless you're new to Medicare or meet a special exception, you can only join during the Medicare Open Enrollment Period, which occurs from October 15 to December 7. **If this is your first time enrolling in an MSA plan, you may cancel this enrollment by December 15, 2025.**

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Network Health Prime covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Network Health Prime between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Network Health Prime after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Network Health Prime each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You must live in the United States for 183 or more days during the year in which the enrollment becomes effective.
- You're a United States citizen or lawfully present in the United States.
- You aren't currently getting hospice care. (If you begin hospice care after you enroll, you can stay a member of our plan.)
- You **don't** have the following types of additional health benefits:
    - You don't have other health coverage that would pay the MSA plan deductible, including benefits under an employer or union group health plan,
    - You don't get benefits from the Department of Defense (TRICARE) or the Department of Veterans Health Administration (VA),
    - You aren't a retired federal government employee and part of the Federal Employee Health Benefits Program (FEHBP), or
    - You aren't eligible for Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources).

Section 2.2 Plan service area for Network Health Prime

Network Health Prime is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes these states: Wisconsin

If you move out of our plan's service area, you can't stay a member of this plan. Call our member experience team at 800-378-5234 (TTY users call 711) to see if we have a plan in your new area.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. Citizen or Lawful Presence

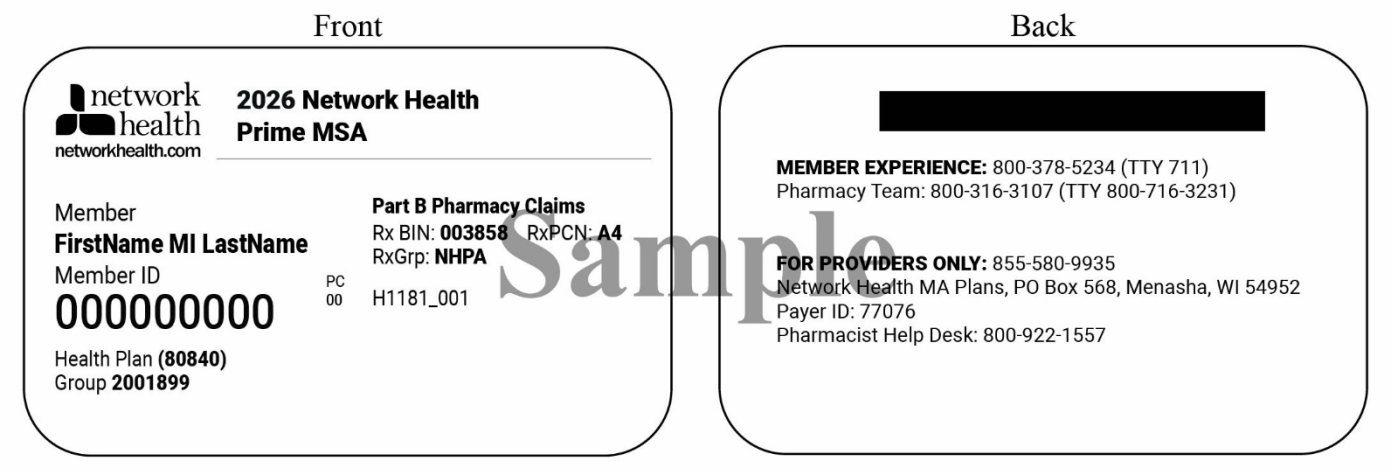
You must be a U.S. citizen or lawfully present in the United States to be a member of Medicare Health Plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Network Health Prime if you're not eligible to stay a member of our plan. Network Health Prime must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your member ID card whenever you get services covered by our plan. If you don't use our plan member ID card when getting services, you'll have to submit a claim to our plan. (For information about submitting a claim, go to Chapter 5, *Asking us to pay our share of a bill for covered medical services*.). You should also show the provider your Medicaid care, if you have one. Sample member ID card:

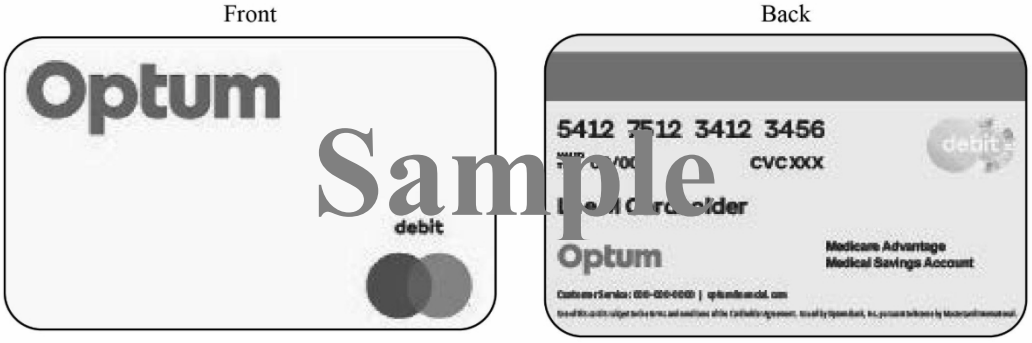
Medical Member ID Card



DON'T use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Network Health Prime member ID card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services or participate in Medicare-approved clinical research studies (also called clinical trials).

You'll also get a debit card to use to pay for qualified medical expenses with money from your MSA savings account.

Debit Card



If our plan member ID card or debit card is damaged, lost, or stolen, call our member experience team at 800-378-5234 (TTY users call 711) right away and we will send you a new card.

SECTION 4 Summary of Important Costs for 2026

	Your Costs in 2026
Monthly plan premium* Go to Section 4.1 for details.	**$0**
Yearly deposit	**$1,750**
Yearly deductible	**$4,000**
All Medicare-covered services	**Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.** **After you meet your deductible, you pay $0 for Medicare-covered services.**

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Section 4.1 Plan Premium

You don't pay a separate monthly plan premium for Network Health Prime. (You must continue to pay your Medicare Part B premium).

If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. If you have questions about our plan premiums, please call our member experience team at 800-378-5234 (TTY users call 711). Dental optional supplemental benefits are available for a monthly premium of $49.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook, the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A, if aren't eligible for premium-free Part A.

Many members are required to pay other Medicare premiums. As explained above, to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B.

Your copy of the *Medicare & You 2026* handbook gives information about these premiums in the section called *2026 Medicare Costs*. This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare gets a copy of the *Medicare & You 2026* handbook each year. Those new to Medicare get it within a month after first signing up. Download a copy of the *Medicare & You 2026* handbook from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.1 for details. Dental optional supplemental benefits are available for a monthly premium of $49.

SECTION 5 Keep your plan membership record up-to-date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your personal doctor.

We use information in your membership record to provide your coverage. Because of this, it's very important that you help to keep your information up-to-date.

If you have any of these changes, let us know:

- Changes to your name, address or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling our member experience team at 800-378-5234 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

CHAPTER 2: Phone numbers and resources

SECTION 1 Network Health Prime contacts

For help with claims, billing, or member ID card questions, please call or write to Network Health Prime member experience team at 800-378-5234 (TTY users call 711). We'll be happy to help you.

Member Experience Team – Contact Information	
Call	800-378-5234 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m. Our member experience team also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	920-720-1905
Write	Network Health Medicare Advantage Plans PO Box 120 1570 Midway Pl. Menasha, WI 54952
Website	networkhealth.com

How to contact the Optum Bank MSA Contact Center

For questions about your MSA savings account and debit card call Network Health Prime member experience team at 800-378-5234 (TTY users call 711) and we can connect you to the Optum Bank MSA Contact Center. If you prefer, you may contact Optum Bank MSA Contact Center directly at the telephone number or address listed below.

Optum Bank MSA Contact Center – Contact Information	
Call	866-234-8913 Calls to this number are free. 24 hours a day, seven days a week.
TTY	711 Calls to this number are free. 24 hours a day, seven days a week.
Fax	800-765-6766
Write	customercare@optum.com
Website	optumbank.com

Note: Optum Bank or the trustee that you've chosen can only assist you with your MSA account and/or debit card. They're unable to assist you with any benefit issues. For benefit issues, call our member experience team at 800-378-5234 (TTY users call 711).

For more information about your MSA trustee services provided by Optum Bank, refer to your deposit agreement and disclosure statement.

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	800-378-5234 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	Coverage Decisions: 920-720-1916 Appeals: 920-720-1832
Write	Network Health Medicare Advantage Plans Attn: Appeals and Grievances PO Box 120 1570 Midway Pl Menasha, WI 54952
Website	networkhealth.com

How to make a complaint about your medical care

You can make a complaint about us, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information	
Call	800-378-5234 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	920-720-1832
Write	Network Health Medicare Advantage Plans Attn: Appeals and Grievances PO Box 120 1570 Midway Pl. Menasha, WI 54952
Medicare website	To submit a complaint about Network Health Prime directly to Medicare, go to Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care you got

If you have got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	800-378-5234 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	920-720-1905
Write	Network Health Medicare Advantage Plans PO Box 120 1570 Midway Pl. Menasha, WI 54952
Website	networkhealth.com

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, seven days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit Medicare.gov to tell Medicare about any complaints you have about Network Health Prime:. **To submit a compliant to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Wisconsin, the SHIP is called Wisconsin SHIP.

Wisconsin SHIP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Wisconsin SHIP counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Wisconsin SHIP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Wisconsin SHIP – Contact Information	
Call	1-800-242-1060
TTY	711
Write	Wisconsin State Health Insurance Assistance Program 1402 Pankratz Street, Suite 111 Madison, WI 53704-4001
Email	BOALTC@wisconsin.gov
Website	dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Wisconsin, the Quality Improvement Organization is called Commence Health Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) Program.

Commence Health BFCC-QIO Program has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health BFCC-QIO Program is an independent organization. It's not connected with our plan.

Contact Commence Health BFCC-QIO Program in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Commence Health BFCC-QIO Program – (Wisconsin's Quality Improvement Organization) Contact Information	
Call	888-524-9900 Available Monday – Friday from 9 a.m. to 5 p.m. Saturday, Sunday and federal holidays from 10 a.m. to 4 p.m. (local time)
TTY	711
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
Website	livantaqio.com/en/states/wisconsin

SECTION 5 Social Security

Social Security determines eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

Social Security - Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available Monday - Friday from 8 a.m. to 7 p.m. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Available Monday – Friday from 8 a.m. to 7 p.m.
Website	ssa.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Program, contact Wisconsin Medicaid. (Note that people with Medicaid coverage aren't eligible for a Medicare MSA plan.)

Wisconsin Medicaid – Contact Information	
Call	1-800-362-3002 Available Monday – Friday from 8 a.m. to 6 p.m.
TTY	711
Write	Department of Health Services 1 West Wilson St. Madison, WI 53703 memberservices@wisconsin.gov
Website	dhs.wisconsin.gov/medicaid

SECTION 7 Railroad Retirement Board (RBB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get your Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "4" to speak with an RRB representative Monday – Friday from 9 a.m. to 3:00 p.m. Press "2" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or our member experience team at 800-378-5234 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call (1-877-486-2048).

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term *providers* also includes hospitals and other health care facilities.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, Network Health Prime must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Network Health Prime will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider in the United States who is eligible to provide services under Original Medicare.**
    - You must show our plan member ID card every time you visit a provider. A provider can decide at each visit whether to accept the payment amount, and thus whether to treat you. You may get plan services and equipment from any licensed provider in the United States.

Network Health Prime **doesn't** require you to get approval in advance for medically necessary covered services. If you have any questions about whether we'll pay for any medical service that you're considering, ask us whether we'll cover it before you get it.

Section 1.3 Medical savings accounts and drug coverage

The law doesn't allow Medicare Advantage MSA plans to offer Medicare drug coverage. If you have a Medicare MSA plan, you can also join a Medicare drug plan to get coverage. Money you use from your MSA savings account on drug plan deductibles or cost sharing **won't** count towards your MSA plan

deductible, but it'll count towards your drug plan's out-of-pocket costs. If you're interested in enrolling in a Medicare drug plan or want to see what plans are available in your area, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Generally, unless you're new to Medicare or meet a special exception, you can only join during the Medicare Open Enrollment Period, which occurs from October 15 to December 7.

Note that even if you aren't enrolled in a Medicare drug plan, money spent from your MSA savings account on prescription drugs are considered "qualified medical expenses" for tax-reporting purposes and aren't taxed. Go to the discussion on tax-reporting responsibilities for members of MSAs in Chapter 6, Section 2.1 for more information on qualified medical expenses.

SECTION 2 How to use the money in your medical savings account

Section 2.1 How the medical savings account works

Our plan makes the deposit into your medical savings account at the beginning of each calendar year. (Members who become entitled to Medicare in the middle of the year and enroll in our plan at that time will get their deposit in the first month they're covered under our plan.) Only our plan can make deposits into your account; you can't deposit your own money. The deposit amount will be less than your deductible amount.

You can use the money in your account to pay for medical expenses, but only Medicare Part A and Part B covered services count toward your deductible (go to Section 2.2 for more information).

- If you use all the money in your account and haven't met your deductible, you must pay for all your medical expenses out-of-pocket until you reach your deductible.
- If you don't use all the money in your account, the money left in your account at the end of the year will stay in your account. If you stay with our plan next year, a new deposit will be added to any leftover amount.

Once you get your initial deposit, you may move the deposit to a savings account that's offered through your own bank or financial institution. If you move your deposit, you'll be responsible for keeping track of your account balance.

How can I access the money in my account?

You will receive a debit card from our banking partner, Optum Bank. You may receive your debit card before your MSA funds are deposited into your MSA account. **To avoid bank penalties, please call our member experience team for confirmation that the money has been deposited into your MSA account before you use your MSA account debit card.** If you need to pay for qualified expenses prior to receiving notice that your funds are available, you may reimburse yourself for the payment(s). See Section 2.2 for more information about the Qualified Medical Expenses the account money may be used for and see Section 2.3 for information on keeping track of your expenses.

Section 2.2 Types of expenses the money in the account can be used for

You can use the money in your account to pay for medical expenses, but **only Medicare Part A and Part B covered services count toward your deductible**. You're responsible for handling the money in your account. This includes deciding which types of expenses to pay.

To avoid taxes and penalties, you must use the money in your account for Qualified Medical Expenses. Qualified Medical Expenses are the same types of services and products that could be deducted as medical expenses on your yearly income tax return. Again, only Medicare Part A and B covered services count toward your deductible:

- Some services, like doctors' visits, lab tests, and hospital stays, are Qualified Medical Expenses and are covered by Medicare Part A or Part B. If you use the money in your account for this type of expense, the money won't be taxed, *and* it'll count toward our plan deductible.
- Other services, like dental care, vision care, and Part D drugs, are Qualified Medical Expenses, but aren't covered by Medicare Part A or Part B. If you use the money in your account for this type of expense, the money won't be taxed. However, these expenses won't count toward your deductible.

To avoid a tax on withdrawals from your account, you need to file Form 1040, U.S. Individual Income Tax Return, and Form 8853 each year to report your Qualified Medical Expenses. For a complete list of the services and products that count as Qualified Medical Expenses and for other tax information, call the Internal Revenue Service at 1-800-TAX-FORM (1-800-829-3676). Ask for a free copy of the IRS publication #502, *Medical and Dental Expenses*. Request the IRS publication #969 to get more information about the tax Form 8853 or visit IRS.gov and select *Forms and Publications* to view or print copies.

If you use the money in your account for non-qualified expenses, it'll be taxed as part of your income and subject to an additional 50 percent tax penalty. Each year, you get a 1099-SA form from your MSA trustee that includes all the withdrawals from your account. You'll need to show that you have had qualified medical expenses in at least this amount, or you may have to pay taxes and additional penalties.

For more information about your tax reporting responsibilities, go to Chapter 6, Section 2.1.

Section 2.3 How to keep track of your expenses

Keep any health care bills or receipts you get in one place to make it easy to summarize your account usage for tax purposes.

If you keep your deposit in the trustee we have selected, you'll get a monthly statement that lists your account activity. You can also get information on whether your expenses count toward your deductible.

If you move your deposit to a different trustee or financial institution, you're responsible for tracking your own expenses.

SECTION 3 How to get services in an emergency or disaster

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval from our plan. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call utilization management at 920-720-1602 or 866-709-0019, Monday – Friday from 8 a.m. to 5 p.m., to share this information.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. If you decide to get follow-up care from the provider treating you, then you should tell them of your coverage as soon as possible by showing them your plan member ID card. The plan will pay for all covered services, including non-emergency care that you get from any provider in the United States who is eligible to provide services under Original Medicare.

Section 3.2 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit the following website: networkhealth.com/medicare/medicare-pdfs/medicare-disaster-policy_f_508.pdf for information on how to get needed care during a disaster.

SECTION 4 What if you're billed directly for the full cost of covered services?

Before you reach your deductible, you must pay the full cost of your covered services. Even though you must pay for the services, you must submit a claim to our plan so that we can count your expenses towards your deductible.

After you meet the deductible, we'll pay for your covered services. If you get a bill, you shouldn't pay it – submit the bill to us for payment. If you have already paid the bill, submit a payment request to us so that we can pay you back.

If you paid for your covered services, or if you have got a bill for the full cost of covered medical services, you can ask us to pay our share the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Network Health Prime covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network and without authorization, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. The payments for services received after you reach the benefit limitation will not apply toward your out-of-pocket maximum. You can call our member experience team when you want to know how much of your benefit limit you have already used.

If you have questions about whether we'll pay for any medical service or care that you're considering, you have the right to ask us whether we'll cover it before you get it. You also have the right to ask for this in writing. If we say we won't not cover your services, you have the right to appeal our decision not to cover your care.

Go to Chapter 7 for more information on what to do if you want a coverage decision from us or want to appeal a decision we already made.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more–for example, if you already paid the Original Medicare cost-sharing amount–we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. Therefore, if you have met your yearly deductible, you'll pay nothing for the items and services you get as part of the study. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.

- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies,* available at Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following condition applies:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

Medicare inpatient hospital coverage limits apply. Please see the Medical Benefits Chart in Chapter 4 for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own the durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Network Health Prime, however, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances we'll transfer ownership of the DME item to you. Call our member experience team at 800-378-5234 (TTY users call 711) for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Network Health Prime will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Network Health Prime or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After five years, you can choose to stay with the same company or go to another company. At this point, the five-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Network Health Prime. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

The only type of out-of-pocket cost you have in our plan is your yearly deductible. The **deductible** is the amount you must pay for medical services before our plan begins to pay its share. Go to section 1.2 for more information about your yearly deductible.

Section 1.2 Your yearly deposit and plan deductible

Our plan makes a yearly deposit into your medical savings account. Our plan also has a deductible that you must meet before our plan pays for your covered services. The table below provides more information about the deposit and deductible.

Deposit and Deductible Amounts

Deposit/Deductible	Amount
Yearly Deposit This is the amount that Medicare deposits into your medical savings account. You can use the money in your account to pay your health care costs, including health care costs that aren't covered by Medicare. (But only funds used to pay for Medicare Part A and Part B services will count toward your yearly deductible.)	$1,750 This is how much our plan deposits in your medical savings account. **For members who join after January 1, 2026, this amount may be adjusted (pro-rated) for the number of months remaining in the year.**
Yearly Deductible This is the amount you have to pay out-of-pocket for covered Medicare Part A and Part B services before our plan will pay for your covered services. Until you have paid the deductible amount, you must pay the full cost of your covered services. Once you meet your	$4,000 This is how much you must pay for your Part A and Part B services before our plan will pay for your covered services. **For members who join after January 1, 2026, this amount may be adjusted**

Deposit and Deductible Amounts	
deductible, our plan will pay 100 percent of the costs for covered Part A and Part B services for the rest of the calendar year.	**(pro-rated) for the number of months remaining in the year.**

Section 1.3 Providers aren't allowed to balance bill you

As a member of Network Health Prime, you have an important protection because once you meet your deductible, we don't allow providers to bill you for any additional charges for services covered under our plan (called **balance billing**). This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Network Health Prime covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. *Medically necessary* means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Prior authorization, prior notification or referral aren't required as a condition of coverage when you get medically necessary plan covered services.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE 1-800-633-4227 (TTY users call 1-877-486-2048).
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

 This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner or clinical nurse specialist.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	

Ambulance services
• Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.
• Medicare will only cover ambulance services to the nearest appropriate medical facility that can provide the care you need. If you choose to be transported to a facility that is farther away, Medicare's payment will be based on the charge to the closest appropriate facility.
• **The ambulance benefit is a transport benefit**. If 911 is contacted and an ambulance is sent to transport you, you may be held liable for payment in these situations:
  ○ You decline the ambulance ride
  ○ You take the ambulance, and it is determined your symptoms are not emergent
	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.
	After you meet your deductible, you pay $0 for Medicare-covered services.

Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months. **Note:** Your Annual physical exam differs from your annual wellness visit. For more information about what type of exam you are receiving please discuss this with your personal doctor.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary:	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.

Covered Service	What you pay
procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	After you meet your deductible, you pay $0 for Medicare-covered services.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months • 2D and 3D mammograms	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. For more information on Peripheral Arterial Disease (PAD) rehabilitation see Supervised exercise therapy benefit in this chart.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure and give you tips to make sure you're eating healthy.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
Chiropractic services Covered services include: • We cover **only** manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified provider. We don't cover maintenance chiropractic care, exams or x-rays. You're responsible for 100% of the cost of maintenance chiropractic care.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Chronic pain management and treatment servicdes Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than three months). Services may include pain assessment, medication management, and care coordination and planning.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Preferred blood glucose monitors, preferred blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
(including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Note:** Preferred supplies for your continuous glucose monitoring device are also covered.	
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at networkhealth.com. **Note:** As a newly enrolled member under a current durable medical equipment rental agreement, you will need to start your 13-month rental over unless you can provide proof of rental documentation from your durable medical equipment supplier. For more information, please contact our member experience team. To acquire ownership for certain types of durable medical equipment, the plan will pay the fee schedule amounts on a monthly rental basis, not to exceed a period of continuous use of 13 months. In the tenth month of rental, you may be given a purchase option. In some cases, as a member of Network Health Prime (MSA), some rented durable medical equipment items such as oxygen equipment may not be eligible for ownership, no matter how many copayments you make for the item while a member of our plan. The plan will make monthly rental payments for up to 36 months during a period of continuous use. However, for oxygen equipment, once the 36-month payment cap has been reached, the supplier retains ownership of the equipment. Title of the equipment does not transfer to you. Additionally, the supplier who received payment for the 36th rental month must continue to provide the oxygen equipment and contents until the reasonable useful lifetime of the equipment has been reached (five years) or as long as you have a medical need for the oxygen. If you still need the equipment - you meet the medical necessity for the	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services. Your cost sharing for Medicare oxygen equipment coverage is $0 after you meet your deductible.

Covered Service	What you pay
oxygen - after the five-year reasonable useful lifetime of the equipment has been reached, a new capped rental period may begin. **Note:** Traditional insulin pumps (insulin pumps that use tubing) such as Medtronic and Tandem are covered under Medicare Part B. Tubeless insulin pumps, such as Omnipod, are covered under your Medicare Part D prescription drug benefit. This plan does not have Part D prescription benefit coverage. If you have questions about your medical costs or have received DME when you travel, please call our member experience team.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. **Note**: Medicare Part B generally doesn't pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in the emergency room.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months. For women who are pregnant, we cover: • Up to three screening exams during a pregnancy.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week) • Physical therapy, occupational therapy and speech therapy ○ Physical, occupational and speech therapy services provided by an outpatient provider while you're receiving any home care services aren't covered unless the home care agency agrees to cover the cost of the outpatient therapies. • Medical and social services • Medical equipment and supplies	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with the plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit. • Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services
Hospice care* You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area,	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Network Health Prime.

Covered Service	What you pay
including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services that are not related to your terminal prognosis:** You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. **Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.**	
* Your cost sharing for services covered by Original Medicare do not apply toward the annual out-of-pocket maximum.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • *Hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B* • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules such as tetanus, or tetanus diphtheria and pertussis or tetanus and diphtheria, when related to the **treatment of an injury** or **direct exposure** to a disease or condition.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient	Until you meet your yearly deductible, you pay up to 100%

Covered Service	What you pay
hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If Network Health Prime (MSA) provides the transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Facilities located within the service area and in the Madison or Milwaukee metropolitan areas are considered within the normal community patterns of care. Indiana University Health is also considered in the normal community patterns of care for intestinal transplants only. Transportation and lodging are covered up to $5,000 each plan year. • Only travel and lodging expenses incurred during the period that begins with the first date of service for the transplant and ending 180 days after the transplant are covered. • Lodging reimbursement is limited to the United States General Services Administration per diem rate. • Mileage reimbursement is limited to the Internal Revenue Service medical rate.	of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
• Only the following types of travel expenses are reimbursable: auto mileage, economy class airfare, train fare, parking, tolls and shuttle/bus fare. **Note:** Only the cost of transportation between the member's residence located in Network Health Prime's (MSA) service area to the designated transplant facility and between the lodging facility and transplant facility is reimbursable. You will be reimbursed for traveling and lodging only if all these criteria are met: o You submit all necessary documentation (such as receipts, lodging verification, etc.) to this address: Network Health Medicare Advantage Plans PO Box 120 1570 Midway Pl. Menasha, WI 54952 o You receive services outside the community pattern of care. Which excludes facilities located within the service area, Madison or Milwaukee metropolitan area. For intestinal transplants, Indiana University Health is considered in the normal community patterns of care. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint. • Physician services **Note:** To be inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. You are inpatient starting the day you are formally admitted to the hospital with a doctor's order and the day before you are discharged is your last inpatient day. For example, if you arrive at the hospital at 10 a.m., your first midnight is that night, this counts as one full day. From that midnight on, each midnight will be a day as an inpatient. If you are discharged before midnight on your last day, then that day does not count toward the total days. If you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet called *Medicare Hospital Benefits*. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or	

Covered Service	What you pay
by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. You get up to 190 days in an inpatient psychiatric hospital in a lifetime. The 190-day limit doesn't apply to mental health services provided in a psychiatric unit of a general hospital.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Inpatient stay: Covered services you get in a hospital or skilled nursing facility during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services. • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump that uses tubing, like Medtronic and Tandem) is covered under Medicare Part B. Insulin furnished through a tubeless insulin pump, such as Omnipod, is covered under the Medicare Part D drug benefit. This plan does not have Part D drug coverage. • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia. • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision. • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug. • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B. • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding)	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.

Covered Service	What you pay
• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	After you meet your deductible, you pay $0 for Medicare-covered services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations. • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Diagnostic mammograms • Other outpatient diagnostic tests	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. **Note**: Medicare Part B generally doesn't pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in an outpatient setting. If you are enrolled in a Medicare prescription drug plan (Part D) or have other prescription drug coverage, self-administered drugs may be eligible for coverage under that plan. Please refer to that plan's coverage for details. Get more information in the Medicare fact sheet called *Medicare Hospital Benefits.* This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital. • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it. • X-rays and other radiology services billed by the hospital. • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA) or other Medicare-qualified mental health care professional as allowed under applicable state laws.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Outpatient substance use disorder services Outpatient mental health care - Medicare covers mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist or physician assistant in an office setting, clinic or hospital outpatient department. Medicare covers substance abuse treatment in an outpatient treatment center if the center has agreed to participate in the Medicare program.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. **Note:** Medicare Part B generally doesn't pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in an outpatient setting. If you are enrolled in a Medicare prescription drug plan (Part D) or have other prescription drug coverage, self-administered drugs may be eligible for coverage under that plan. Please refer to that plan's coverage for details.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • Consultation, diagnosis, and treatment by a specialist • Palliative care services • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location. • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within six months prior to your first telehealth visit. o You have an in-person visit every 12 months while receiving these telehealth services. o Exceptions can be made to the above for certain circumstances. • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** o You're not a new patient **and** o The check-in isn't related to an office visit in the past seven days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** o You're not a new patient **and**	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
○ The evaluation isn't related to an office visit in the past seven days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other doctors by phone, internet, or electronic health record. • Second opinion prior to surgery **Note:** Medicare-covered Practitioner/Provider services received through telehealth will be covered the same as if you visited your provider in-person. Telehealth services (excluding behavioral health and dermatology) received from our partner, MDLIVE, are considered Medicare-covered Practitioner/Provider services.	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs. • Routine foot care services are considered medically necessary once in 60 days. More frequent services are considered not medically necessary	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. • A one-time hepatitis B virus screening.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible)	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by skilled nursing facilities. • Physician/Practitioner services You're covered for up to 100 days per admission. (Facility transfers are not considered a "new" admission.)	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount.

Covered Service	What you pay
• Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with the patient getting up to eight sessions per year.)	After you meet your deductible, you pay $0 for Medicare-covered services.
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to obtain this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Covered Service	What you pay
checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have two separate cataract operations, you can't reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Corrective lenses/frames and replacements needed after a cataract removal without a lens implant are not covered. Tinting, scratch protection or other enhancements to the eyewear are also not covered. **Note:** Only the conventional intraocular lens is covered with either the blade or laser removal of a cataract. Insertion of lenses to correct vision are not covered. **Note:** Eye refractions performed in conjunction with Medicare covered eye exams are not covered.	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.
Welcome to Medicare preventive visit Our plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit	Until you meet your yearly deductible, you pay up to 100% of the Medicare-approved amount. After you meet your deductible, you pay $0 for Medicare-covered services.

Section 2.1 Extra optional supplemental benefits you can buy

Our plan offers some extra benefits that aren't covered by Original Medicare and not included in your benefits package. These extra benefits are called **Optional Supplemental Benefits.** If you want these optional supplemental benefits, you must sign up for them and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

As a member of the plan, you have the option to purchase an optional supplemental dental benefit package. You may elect this option upon your initial enrollment into the plan, during the Open Enrollment Period, Medicare Advantage Open Enrollment Period or during a Special Election Period, if you qualify for one. This optional supplemental benefit cannot be combined with any other dental benefits that may be offered on your plan. The optional supplemental dental benefit is only available if you are enrolled in Network Health Prime. If you terminate your Network Health Prime policy or lose eligibility, your supplemental dental benefit will also terminate. The monthly premium for the optional supplemental dental benefit in 2026 is $49. This is in addition to your Medicare Parts A and/or B premium, if applicable. The deductible and coinsurance for the covered services do not apply toward your out-of-pocket maximum described in Chapter 4. Your supplemental dental coverage will be effective on the date your Network Health Prime coverage becomes effective.

Your optional supplemental dental benefits will continue if you move to another Network Health Medicare Advantage Plan that offers this benefit unless you choose to end the benefit.

You may end your optional supplemental dental benefits by giving us written notice that you'd like to end your coverage. Written notice must be sent or faxed to the below address:

Network Health Insurance Corporation
Attn: Medicare Enrollment Services
1570 Midway Pl.
Menasha, WI 54952
Fax to 920-720-1933

Note: You may be balance billed if you receive services from an out-of-network dentist.

Your coverage of supplemental dental benefits will end on the last day of the month following our receipt of your request to end coverage or the date you request that your coverage ends, if later. If you have paid a premium in advance, your premium will be refunded for any unused months.

If you end coverage for supplemental dental benefits and later wish to re-enroll, you will need to wait until the next Open Enrollment Period.

You may cancel your enrollment for supplemental dental benefits verbally or in writing prior to your effective date. After the effective date of your supplemental dental benefits, you will need to submit your request in writing.

Additional services you can purchase	What you pay
Dental Optional Supplemental Benefit The dental optional supplemental benefit package is available for an additional monthly premium of $49. Included are the following services: **Non-Medicare covered preventive dental services** • Routine dental exams and cleanings twice a year • Fluoride treatments once a year • Bitewing x-rays once a year **Non-Medicare covered comprehensive dental services** • Emergency palliative treatment • Restorative services • Endodontics • Periodontics • Extractions • Prosthodontics • Oral Surgery • Relines and repairs to bridges and dentures Up to $1,000 annual maximum benefit applies to both in and out-of-network services received for non-Medicare covered dental services. If you receive services from a dentist that does not participate in the dental network, you will be responsible for the difference between the payment and the amount charged by the non-participating dentist. Please contact our member experience team (phone numbers located in the back of this document) with any questions. To view the certificate of coverage for the dental optional supplemental benefit, visit networkhealth.com/medicare/plan-materials or contact the member experience team. Please contact our member experience team (phone numbers located in the back of this document) with any questions. *	Monthly Premium: $49 Annual Maximum: $1,000 Comprehensive Deductible: $100 **In-Network** **0%** of the allowed amount for non- Medicare-covered preventive and diagnostic dental services. Deductible does not apply. **50%** of the allowed amount for non-Medicare-covered basic and major dental services after the deductible. **Out-of-Network** **20%** of the allowed amount for non-Medicare-covered preventive and diagnostic dental services. Deductible does not apply. **50%** of the allowed amount for non-Medicare-covered basic and major dental services after the deductible.

* Cost sharing for non-Medicare covered services *does not* apply toward the annual out-of-pocket maximum.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances. Please refer to the Medical Benefits Chart for additional information.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance) except when medically necessary	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies).
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition

Homemaker services including basic household help, such as light housekeeping or light meal preparation	Not covered under any condition
Maintenance chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Outpatient Part D prescription drugs including drugs for treatment of sexual dysfunction, such as erectile dysfunction, impotence and anorgasmy or hyporgasmy.	Not covered under any condition
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Prescriptions or refill of prescriptions that are lost, stolen or damaged	Not covered under any condition
Private duty nurses	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Residential AODA or mental health treatment	Not covered under any condition
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine dental care, such as cleanings, fillings or dentures	Additional comprehensive dental coverage is available. (Go to Chapter 4, Section 2.1 for more information on a dental optional supplemental benefit).
Routine eye examinations, eyeglasses, refractive eye surgeries including but not limited to radial keratotomy, LASIK surgery and other low vision aids	Eye exam and one pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Please refer to the Vision care benefit in the Medical Benefits Chart for additional information.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids	Not covered under any condition

Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Services provided to veterans in Veterans Affairs (VA) facilities.	Emergency services that are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
Surgical treatment for morbid obesity	Covered only when medically necessary and covered under Original Medicare.

CHAPTER 5: Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

When you get care, you should ask the provider to bill our plan for your services. We'll look at the bill and decide whether the services should be covered and will let you know who should pay for them.

If you get a bill for an item or services, send the bill to us. Examples for when you should send us a bill:

1. When you get a bill for an item or services even though you haven't yet met your deductible

Before you reach your deductible, you must pay the full cost of your covered services. Even though you're responsible for the cost, still send our plan the bill before you pay it so we can make sure you've been billed the correct amount. After you pay a bill, send us a copy of the bill and your payment so that we can count your expenses towards your deductible.

2. When you get a bill for an item or services after you have met your deductible

After you meet the deductible, our plan will pay for your covered services. If you get a bill, you shouldn't pay it. Submit it with a payment request to us. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered and you haven't paid the bill, we'll pay the provider directly. If we decide they should be covered and you've already paid the bill, we'll mail you your reimbursement.

After you meet your deductible, you don't have to pay anything for services covered by our plan. We don't allow providers to add additional separate charges, called *balance billing*. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges. For more information about *balance billing*, go to Chapter 4, Section 1.3.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills, for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision.** If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay a bill or to count your expenses toward your deductible

When you want us to pay a bill or to pay you back for a bill you've already paid, send us a request for payment, along with your bill and documentation of any payment you made. Even if you haven't met your deductible for the year, still send us your bill and documentation of your payment so we can count your expenses toward your deductible. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Download a copy of the form from our website (networkhealth.com) or call our member experience team at 800-378-5234 (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:
For Medical Claims:
Network Health Medicare Advantage Plans
PO Box 568
1570 Midway Pl.
Menasha, WI 54952

For Part B Prescription Claims
Express Scripts
P.O. Box 52017
Phoenix, AZ 85082

You must submit your medical claim to us within 12 months and your Part B prescription drug claims within 36 months of the date you got the service, item or drug.

Call our member experience team at 800-378-5234 (TTY users call 711) if you have questions. If you don't know what you should have paid, or you get bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you've already sent to us.

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we'll pay for our share of the cost.
    - If you met your yearly deductible and already paid for the service, we'll mail your reimbursement to you.
    - If you met your yearly deductible and haven't paid for the service yet, we'll mail the payment directly to the provider.
    - If you haven't met your deductible yet, we'll tell you how much you should be billed by the provider.
- If we decide that medical care is *not* covered, or you did *not* follow the rules, we won't pay for our share of the cost. Instead, we'll send you a letter that explains the reasons why we aren't sending the payment you've asked for and your rights to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment or when we turned down your request to count medical expenses you've paid (either with money from your MSA account or out-of-pocket) toward our plan deductible. You may also appeal if you believe that, before to meeting the deductible, you've been required to pay more for a service than the Medicare allowable amount. For the details on how to make this appeal, go to Chapter 7.

CHAPTER 6: Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, in large print, or other alternate formats at no cost, if you need it. We're required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, call our member experience team at 800-378-5234 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with the discrimination complaints coordinator (contact information is at the end of this booklet). You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 You have a right to be treated with respect, with recognition of your dignity and a right to privacy

You'll be treated with courtesy and kindness. You'll be treated equally, and we'll listen to you. Your choices, as well as rights to privacy will be honored.

Section 1.3 We must ensure you get timely access to covered services

You may seek care from any provider in the United States who is eligible to provide services under Original Medicare. You should always (except possibly in emergencies) show the provider your MSA plan membership card.

You don't need a referral or prior approval from our plan to get covered services.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your *personal health information* includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells you about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we're required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call our member experience team at 800-378-5234 (TTY users call 711).

Network Health Insurance Corporation is committed to protecting the privacy of your confidential health information. This includes all oral, written and electronic protected health information across the organization. We're required by law to:

- Maintain the privacy and security of your protected health information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Follow either federal or state law, whichever is more protective of your privacy rights.
- Let you know promptly if a breach occurs which may have compromised the privacy or security of your information.
- Abide by the terms of our Notice of Privacy Practices.

We're committed to ensuring your health information is used responsibly by our organization. We may use and disclose your health information without your written authorization for payment, treatment, health care operations or other instances where written authorization is not required by law. In instances where written authorization is required, we'll obtain written authorization before using or disclosing information about you. You may choose to revoke your authorization at any time by notifying us in writing of your decision. This means we'll no longer be able to use or disclose health information about you for the reasons covered by your written authorization, but we'll be unable to take back any disclosures we have already made based on your prior written authorization consent.

For a full copy of the Notice of Privacy Practices please visit our website at networkhealth.com/legal or call our member experience team to request a copy. If you would like to exercise one or more of your rights regarding your health information, please call our member experience team (phone numbers are printed on the back cover of this document).

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about your rights to your health information, you may contact the Privacy Officer at 800-378-5234. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. Network Health can't and won't require you to waive the right to file a complaint as a condition of receiving benefits or services or retaliate against you for filing a complaint with us or with the U.S. Department of Health and Human Services.

Section 1.5 We must give you information about our plan, the organization, and your covered services

As a member of Network Health Prime, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call our member experience team at 800-378-5234 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.6 You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all your choices**. You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say no.** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call our member experience team to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

If you know ahead of time that you're going to be hospitalized, and you signed an advance directive, **take a copy with you to the hospital**.

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Wisconsin Department of Health Services, 1 West Wilson Street, Madison, WI 53703. The telephone number is 1-608-266-1865 (TTY accessible telephone number is 711).

Section 1.7 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do–ask for a coverage decision, make an appeal, or make a complaint–**we're required to treat you fairly**.

Section 1.8 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call our member experience team at 800-378-5234 (TTY users call 711)**

- **Call your local SHIP** at 1-800-242-1060
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 1.9 How to get more information about your rights

Get more information about your rights from these places:

- **Call our member experience team** at **800-378-5234 (TTY users call 711)**
- **Call your local SHIP** at 1-800-242-1060
- **Contact Medicare**
  - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 1.10 You have the right to make recommendations regarding the organization's member rights and responsibilities policy

You can email your recommendations to Network Health at QI@networkhealth.com and our Quality Health Integration Department will review your proposal and make any necessary changes to Network Health's policy.

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, please call our member experience team at 800-378-5234 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan member ID card whenever you get medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.

  - If you have questions, be sure to ask and get an answer you can understand.
  - Supply information (to the extent possible) the organization, its practitioners and providers need in order to provide care.
  - Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
  - Until you meet your yearly deductible, you must pay up to 100 percent of the Medicare-approved amount for your covered Part A and Part B services.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up-to-date and know how to contact you.
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

Section 2.1 Special tax-reporting responsibilities of members of a Medicare MSA plan

Our plan is a Medicare MSA plan. MSA members must file Form 1040, U.S. Individual Income Tax Return, along with Form 8853, *Archer MSAs and Long-Term Care (LTC) Insurance Contracts,* to the Internal Revenue Service (IRS) for any year that distributions are made from their Medicare MSA account to ensure that they're not taxed on their MSA account withdrawals.

These tax forms must be filed for any year in which a MSA account withdrawal is made even if the member has no taxable income or any other reason for filing Form 1040. MSA account withdrawals for qualified medical expenses are tax-free, while account withdrawals for non-medical expenses are subject to both income tax and a 50 percent tax penalty.

- You'll get a statement (Form 1099-SA) from your MSA trustee reporting your MSA savings account distributions by January 31 each year. The trustee is also required to report this information to the IRS.
  - You must file tax forms 1040 and 8853 even if you aren't otherwise required to file an income tax return to avoid owing taxes on MSA account withdrawals.
  - Form 8853, *Archer MSAs and Long-Term Care (LTC) Insurance Contracts*, Section B, is the place to report both your Medicare MSA account withdrawals (which the IRS calls distributions) and on your qualified medical expenses for the year.
  - Form 8853 and Form 8853 Instructions are available at IRS.gov or from 1-800-TAX-FORM (1-800-829-3676). On the Web, look up forms by number at **Forms**. (**Note:** IRS tax code considers Medicare MSAs as a type of *Archer* MSA, therefore, IRS references to *Archer* MSAs include Medicare MSAs.)

- You must file by April 15 of the following year unless you request an extension on your tax return.

Information reported to the IRS on MSA account withdrawals for qualified medical expenses is **not** the same expense information that will count towards your MSA plan deductible. Only Medicare Part A and Part B expenses will count towards your MSA plan deductible. Therefore, you'll also want to keep track of your qualified medical expenses that are also Part A and Part B expenses and that will count towards your MSA plan deductible.

Helpful MSA-related publications related to tax-reporting requirements

These two IRS publications related to Medicare MSAs are available at IRS.gov (look up publications by number) or from 1-800-TAX-FORM (1-800 829-3676).

- IRS Publication 502 (*Medical and Dental Expenses*) defines what types of services generally count as qualified medical expenses for IRS tax purposes.
- IRS Publication 969 (*Health Savings Accounts and Other Tax-Favored Health Plans*) includes information on medical savings accounts, including Medicare MSAs. Publication 969 provides more items and services (in addition to those in Publication 502) that are qualified medical expenses for MSAs.

For more information or help preparing your tax return

Call the IRS toll-free for live telephone help from Monday – Friday, 7 a.m. to 10 p.m. local time, or visit your local IRS office.

- For people: 1-800-829-1040
- For people with hearing impairments: 1-800-829-4059 (TDD)

Face-to-Face Help: In certain areas, IRS also has local offices. Find your local office at IRS.gov/help/contact-your-local-IRS-office.

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.2 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

Uses more familiar words in place of some legal terms. However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call our member experience team at 800-378-5234 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who is not connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which

process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3.

Medicare

You can also contact Medicare for help. To contact Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048.
- Visit Medicare.gov.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, our plan network doctor makes a (favorable) coverage decision for you whenever you get medical care from them or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think that you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include, if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances an appeal request will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call our member experience team at 800-378-5234 (TTY users call 711).**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call our member experience team at 800-378-5234 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at networkhealth.com.
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call our member experience team at 800-378-5234 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at networkhealth.com. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are three different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

- **Section 7**: How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call our member experience team at 800-378-5234 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the five following situations:

1. You aren't getting certain medical care you want, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**

3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**

4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

   Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A fast coverage decision is called an **expedited determination.**

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within seven calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items or services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within seven calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar

days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information on complaints.)

For fast coverage decisions we use an expedited timeframe

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or seven calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, you must explain the reason your appeal is late when you make your appeal in writing. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.

- **If our answer is no to part or all of what you asked for,** we'll automatically forward your appeal to the Independent Review Organization for a Level 2 appeal. The Independent Review Organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within seven calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days to make the decision, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an Independent Review Organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within seven calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the Independent Review Organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term

The formal name for the Independent Review Organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **Independent Review Organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The Independent Review Organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2

- For the fast appeal the Independent Review Organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

- For the standard appeal, if your request is for a medical item or service, the Independent Review Organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the Independent Review Organization must give you an answer to your Level 2 appeal **within seven calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The Independent Review Organization gives you its answer.

The Independent Review Organization will tell you it's decision in writing and explain the reasons for it.

- **If the Independent Review Organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within **72 hours** or provide the service within 14 calendar days after we get the decision from the Independent Review Organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the Independent Review Organization.
- **If the Independent Review Organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the **Part B drug** within **72 hours** after we get the decision from the Independent Review Organization for **standard requests.** For **expedited requests** we have **24 hours** from the date we get the decision from the Independent Review Organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the Independent Review Organization will send you a letter that:
  - Explains the decision.

- Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the Independent Review Organization will tell you the dollar amount you must meet to continue the appeals process.
- Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you've already got and paid for, you aren't allowed to ask for a fast appeal.
- If the Independent Review Organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals

process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within two calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call our member experience team at 800-378-5234 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
    - If you sign the notice more than two calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
    - To look at a copy of this notice in advance, call our member experience team at 800-378-5234 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also see the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call our member experience team at 800-378-5234 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling our member experience team at 800-378-5234 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave to them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal

What happens if the answer is yes?

- If the Independent Review Organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the Independent Review Organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the Independent Review Organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision

If the Independent Review Organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the Independent Review Organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of the three types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it**. If you have questions or need help, call our member experience team at 800-378-5234 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that give details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The Independent Review Organization will also look at your medical information, talk with your doctor, and review information our plan gave them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you it's decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information about your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you it's decision.

What happens if the Independent Review Organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the Independent Review Organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4 and 5

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way as the first two levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept the decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
    - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making Complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our member experience team? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our member experience team or other staff at our plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.

- You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.
- You believe we failed to meet required deadlines for forwarding your case to the Independent Review Organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling our member experience team at 800-378-5234 (TTY users call 711) is usually the first step.** If there's anything else you need to do, our member experience team will let you know.
- **If you don't want to call (or if you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Send your grievance (complaint) in writing to Network Health Medicare Advantage Plans, Attn: Appeals and Grievances, PO Box 120, 1570 Midway Pl., Menasha, WI 54952, via fax at 920-720-1832, or phone by calling 800-378-5234 (TTY 711).
- If you request a fast coverage determination or appeal and we deny your request, we'll call you and send you a letter within 72 hours notifying you that your request will automatically follow the standard grievance and appeals process.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization**.
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Network Health Prime directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Network Health Prime may be **voluntary** (your own choice under permitted situations) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 6 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. You may also be eligible to leave our plan at other times of the year. If this is your first time enrolling in an MSA plan you may cancel this enrollment by December 15, 2025.

- **The Open Enrollment Period** is from October 15 to December 7.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
    - Keep your Medicare Savings Account (MSA) plan and enroll in a separate drug plan (or enroll in a new prescription drug plan if you don't currently have one),
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan, or
    - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain limited situations, members of Network Health Prime may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.

- Usually, when you move
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you have a change in your Medicaid status. (Note that people with Medicaid coverage aren't eligible to enroll in a Medicare MSA plan.)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan (or enroll in a new prescription drug plan if you don't currently have one), or
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change your plan.

If you get Extra Help from Medicare to pay your drug coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.3 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call our member experience team at 800-378-5234 (TTY users call 711)**.
- Find the information in the ***Medicare & You 2026*** handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 3 If you leave our plan in the middle of the year

Section 3.1 What happens to the money in your account if you leave our plan

If you leave our plan in the middle of the year, part of the current year's deposit will be refunded to Medicare. The amount recovered and refunded to Medicare depends on the number of months left in the current calendar year. For example, if you get a $1,200 deposit in your account in January and you leave our plan in March, we'll recover $900 to return to Medicare.

Funds remaining in your account from any previous year belong to you. Recovery applies only to funds deposited into your account for the current year. If you have any questions, call our member experience team at 800-378-5234 (TTY users call 711).

SECTION 4 How to end your membership in our plan

The table below explains how you can end your membership in our plan during permitted timeframes:

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Network Health Prime when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Network Health Primewhen your new plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Call our member experience team at 800-378-5234 (TTY users call 711) if you need more information on how to do this. • You can also call Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Network Health Prime when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., standalone Medicare prescription drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

SECTION 5 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical services and items through our plan.

- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 6 Network Health Prime must end your plan membership certain situations

Network Health Prime must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you get other insurance (to include supplemental policies) that covers all or part of the annual Medicare MSA deductible such as through insurance primary to Medicare, or retirement health benefits
- If you obtain Medicaid coverage
- If you move out of our service area
- If you're away from our service area for more than six months
    - If you move or take a long trip, call our member experience team at 800-378-5234 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General
- If you no longer meet MSA's eligibility criteria due to a mid-year change in eligibility
- If you don't pay the premium for the optional supplemental dental benefit, we'll reduce your coverage to exclude this benefit

If you have questions or would like more information on when we can end your membership call our member experience team at 800-378-5234 (TTY users call 711).

Section 6.1 We <u>can't</u> ask you to leave our plan for any health-related reason

Network Health Prime is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 6.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint (also called a grievance) about our decision to end your membership.

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call our member experience team at 800-378-5234 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, our member experience team can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Network Health Prime, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Third Party Liabilities

As a member of Network Health Prime (MSA), you agree to assign to Network Health Insurance Corporation all rights and claims against any third party for recovery of medical, surgical or hospital care costs that Network Health Insurance Corporation pays or arranges to pay on your behalf. Network Health Insurance Corporation has the right of subrogation against third parties liable or responsible for medical, surgical or hospital care costs that Network Health Insurance Corporation arranges or pays on your behalf.

As a member of Network Health Prime (MSA), you agree to release any medical, surgical or hospital care expense-related claim you may have against a third party when Network Health Insurance Corporation settles or compromises the claim.

As a member of Network Health Prime (MSA), you must notify Network Health Insurance Corporation in writing within 31 days after the start of any legal proceedings against a third party. You may not enter into a proposed settlement, compromise, agreed judgement or release of claims against a third party without Network Health Insurance Corporation's written consent.

As a member of Network Health Prime (MSA), you agree to permit Network Health Insurance Corporation to participate or intervene in any legal proceeding against a third party at Network Health Insurance Corporation's own expense.

CHAPTER 10: Definitions

Allowed Amount – This is the maximum payment the plan will pay.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Network Health Prime, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Calendar Year – Each successive period of twelve (12) months starting on January 1 and ending on December 31.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Complaint - The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. Cost sharing includes any combination of the following three types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Critical Access Hospital – A rural acute care facility providing 24-hour emergency services, acute inpatient and swing-bed care.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of six months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid. You can't be a member of our Medicare Medical Savings Account (MSA) plan if you have Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. Health care services or supplies are considered medically necessary when they meet these requirements:

a) Are necessary to identify, diagnose, or treat a bodily injury or illness;
b) Are consistent with your diagnosis in accord with generally accepted standards of the medical community;
c) Are provided in the least intense, most cost-effective setting or manner needed for your bodily injury or illness.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Medical Savings Account (MSA) Plan – A type of Medicare Advantage Plan that combines a high-deductible health insurance plan with a medical savings account that members can use to pay for their health care costs.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Experience Team (commonly referred to as customer service) – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Observation Services – Observation services are hospital outpatient services given to help the doctor decide if the patient needs to be admitted as an inpatient or can be discharged. Observation services may be given in the emergency department or another area of the hospital.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and aren't included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits to get them.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (**Traditional Medicare** or **Fee-for-service Medicare)** – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Pocket Costs – Go to the definition for **cost sharing** above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

Over-the-Counter (OTC) – Drugs and health-related products that do not need a prescription.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're from in-network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services got from in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services based on specific criteria. As a member of a Medicare Medical Savings Account (MSA) plan, you don't need prior authorization to get services. However, you may want to check with us before getting services to confirm that the service is covered by our plan.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Qualified Medical Expenses - Qualified medical expenses are those expenses that would generally qualify for the medical and dental expenses deduction on your income tax return. These expenses are explained in IRS Publication 502, Medical and Dental Expenses.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Self-Administered Drugs (SADs) – Medications that you would normally take on your own, such as medications to control blood pressure or diabetes.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Network Health Prime Member Experience Team

Member Experience Team – Contact Information	
Call	800-378-5234 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m. Our member experience team also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	920-720-1905
Write	Network Health Medicare Advantage Plans PO Box 120 1570 Midway Pl. Menasha, WI 54952
Website	networkhealth.com

Wisconsin SHIP

Wisconsin SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Contact Information	
Call	1-800-242-1060
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Wisconsin State Health Insurance Assistance Program 1402 Pankratz Street, Suite 111 Madison, WI 53704-4001
Email	BOALTC@wisconsin.gov
Website	dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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:
  - Qualified sign language interpreters
  - 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:
  - Qualified interpreters
  - 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 (711) 800-378-5234 اتصل على الرقم
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 आपकेलिएनिः शु भाषा सहायता सेवाएं उपल होती हैं। सुलभप्रारूपोंमेंजानकारी प्रदान करनेकेलिए उपयुसहायक साधन और सेवाएँभी निः शु 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 보조 기구 및 서비스도 무료로 제공됩니다. 800-378-5234 (TTY : 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-378-5234 (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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network health

1570 Midway Pl.
Menasha, WI 54952
800-378-5234
TTY 711
Monday–Friday, 8 a.m. to 8 p.m.

networkhealth.com