NETWORK HEALTH
MEDICARE ADVANTAGE PLANS

EVIDENCE OF COVERAGE

2021

001

Network Platinum*Plus* PPO

network health

800-378-5234
TTY 800-947-3529
networkhealth.com

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Network Platinum*Plus* (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services you need.
This is an important legal document. Please keep it in a safe place.

This plan, Network Platinum*Plus,* 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 Platinum*Plus.*)

Our member experience team has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

This material is available for free in other formats. For more information, please contact our member experience team at 800-378-5234 (TTY 800-947-3529), Monday – Friday from 8 a.m. to 8 p.m. From October 1, 2020 through March 31, 2021, we are available every day, from 8 a.m. to 8 p.m.

Benefits, premium, deductible and/or copayments/coinsurance may change on January 1, 2022.

The provider network may change at any time. You will receive notice when necessary.

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Accepted 08312020 OMB Approval 0938-1051 (Expires December 31,2021)

2021 Evidence of Coverage

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

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SECTION 1 Introduction

Section 1.1 You are enrolled in Network Platinum*Plus*, which is a Medicare PPO

You are covered by Medicare and you have chosen to get your Medicare health care coverage through our plan, Network Platinum*Plus*.

There are different types of Medicare health plans. Network Platinum*Plus* is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Section 1.2 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered and what you pay as a member of the plan.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of Network Platinum*Plus*.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused, or concerned or just have a question, please contact our plan's member experience team (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Network Platinum*Plus* covers your care. Other parts of this contract include your enrollment form and any notices you receive 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 months in which you are enrolled in Network Platinum*Plus* between January 1, 2021 and December 31, 2021.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Network Platinum*Plus* after December 31, 2021. We can also choose to stop offering the plan or to offer it in a different service area after December 31, 2021.

Medicare must approve our plan each year

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

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Network Platinum*Plus*

Although Medicare is a federal program, Network Platinum*Plus* is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Wisconsin: Brown, Calumet, Dodge, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marquette, Oconto, Outagamie, Portage, Shawano, Sheboygan, Waupaca, Waushara and Winnebago.

If you plan to move out of the service area, please contact our member experience team (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that

will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. Citizen or Lawful Presence

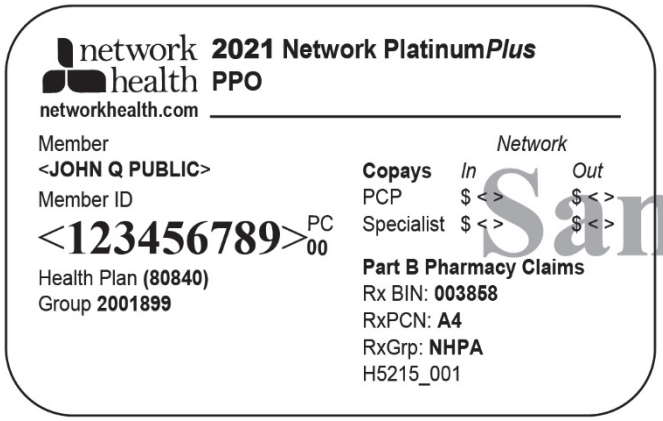
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Network Platinum*Plus* if you are not eligible to remain a member on this basis. Network Platinum*Plus* must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan member ID card – use it to get all covered care

While you are a member of our plan, you must use your member ID card for our plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample member ID card to show you what yours will look like:

Front



Back

Do NOT use your red, white and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Network Platinum*Plus* 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 routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Network Platinum*Plus* member ID card while you are a plan member, you may have to pay the full cost yourself.

If your plan member ID card is damaged, lost, or stolen, call our member experience team right away and we will send you a new card. (Phone numbers for our member experience team are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

The *Provider Directory* lists our in-network providers and durable medical equipment suppliers.

What are "in-network providers"?

In-network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and durable medical equipment suppliers is available on our website at networkhealth.com/find-a-doctor.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *Provider Directory*, you can request a copy from our member experience team (phone numbers are printed on the back cover of this booklet). You may ask our member experience team for more information about our in-network providers, including their qualifications. You can also see the *Provider Directory* on our website at networkhealth.com/find-a-doctor. Both our member experience team and the website can give you the most up-to-date information about changes in our in-network providers.

SECTION 4 Your monthly premium for Network Platinum*Plus*

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2021, the monthly premium for Network Platinum*Plus* is $51. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call our member experience team (phone numbers for our member experience team are printed on the back cover of this booklet). Dental optional supplemental benefits are available for a monthly premium of $38.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those 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. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2021* gives information about these premiums in the section called "2021 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2021* from the Medicare website (www.medicare.gov) or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

There are five ways you can pay your plan premium. At the time of completing the enrollment application, you were required to choose a payment option. If you would like to change your payment option, please call our member experience team for a *Payment Option* form or visit networkhealth.com/medicare/member-resources to download the payment option form.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure your plan premium is paid on time.

Option 1: You can pay by check

Between the 15th and 20th of each month, we will mail you a billing statement indicating your balance due. If you have prepaid for several months in advance, no statement will be sent again until the month before your next payment is due. For example, if your next payment is due June 1st, the billing statement will be mailed between May 15th and 20th, notifying you of your balance due.

Payment is due by the 1st of each month. **Checks should be made payable to Network Health Insurance Corporation,** not CMS or HHS. You can mail your payments to Network Health Insurance Corporation, PO Box 78424, Milwaukee WI 53278-8424. You may also drop off your payments in our lobby at 1570 Midway Place, Menasha WI 54952, Monday - Friday from 8 a.m. to 5 p.m., or 16960 W. Greenfield Avenue, Suite 5, Brookfield, WI 53005, Monday - Friday from 8 a.m. to 4 p.m. If you would like to pay in advance for additional months, please enclose your current statement with your premium payment for each month you are submitting payment. Please call our member experience team (phone numbers are printed on the back cover of this booklet) if you do not receive your statement.

Option 2: Monthly Automatic Bank Withdrawal

With this option, the monthly premium will be deducted from either the designated checking or savings account on the 7th of each month. For tracking purposes, this payment will always be itemized on your monthly bank statement.

Note: If the 7th of the month falls on a non-business day, the withdrawal will be made the next business day. On occasion, due to circumstances beyond our control, a bank withdrawal will occur later than the 7th of the month. The withdrawal **will not** occur earlier than the 7th of the month.

Option 3: Credit Card

With this option, the monthly plan premium will be charged to your credit card on the 7th of each month. For tracking purposes, this payment will always be itemized on your monthly credit card statement.

Option 4: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact our member experience team for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for our member experience team are printed on the back cover of this booklet.) Optional supplemental benefits will not be taken out of your Social Security check and may only be paid by check or credit card.

Option 5: You can have the plan premium taken out of your monthly Railroad Retirement Board check

You can have the plan premium taken out of your monthly Railroad Retirement Board check. If you prefer to do it this way, our member experience team can help you set up your premium payment. (Phone numbers for our member experience team are printed on the back cover of this booklet.) Optional supplemental benefits will not be taken out of your Railroad Retirement Board check and may only be paid by check or credit card.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the **1st day of each month**. If we have not received your premium payment by the **1st day of each month** ***and*** your outstanding account balance is $250.00 or more for three consecutive months, we will send you a notice telling you that your plan membership will end.

If you are having trouble paying your premium on time, please contact our member experience team to see if we can direct you to programs that will help with your plan premium. (Phone numbers for our member experience team are printed on the back cover of this booklet.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of these premiums. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 9 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling 800-378-5234

Monday – Friday from 8 a.m. to 8 p.m. TTY users should call 800-947-3529. You must make your request no later than 60 days after the date your membership ends.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

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

The doctors, hospitals and other providers in the plan's network need to have correct information about you. **These in-network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling our member experience team (phone numbers are printed on the back cover of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our

plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call our member experience team (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether your Medicare Advantage plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital and pharmacy. If you have questions about who pays first or you need to update your other insurance information, call our member experience team (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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SECTION 1 Network Platinum*Plus* contacts (how to contact us, including how to reach our member experience team at the plan)

How to contact Network Health's Member Experience Team

For assistance with claims, billing or member ID card questions, please call or write to Network Platinum*Plus* Member Experience Team. We will be happy to help you.

Method	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	800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with 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

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

You may call us if you have questions about our coverage decision process.

Method	Coverage Decisions 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	800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with 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

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	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	800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. 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
WEBSITE	networkhealth.com

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our in-network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	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	800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. 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	You can submit a complaint about Network Platinum*Plus* directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	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	800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with 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

SECTION 2 Medicare
(how to get help and information directly from the federal Medicare program)

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 (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations, including us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 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 with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Network Platinum*Plus*: • **Tell Medicare about your complaint:** You can submit a complaint about Network Platinum*Plus* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.)

SECTION 3 State Health Insurance Assistance Program (free help, information and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Wisconsin, the SHIP is called The Board on Aging and Long Term Care.

The Board on Aging and Long Term Care is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

The Board on Aging and Long Term Care counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment and help you straighten out problems with your Medicare bills. The Board on Aging and Long Term Care counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	The Board on Aging and Long Term Care (Wisconsin SHIP)
CALL	1-800-815-0015 Ombudsman Program/Volunteer Program 1-800-242-1060 Medigap Helpline
WRITE	The Board on Aging and Long Term Care 1402 Pankratz Street, Suite 111 Madison, WI 53704-4001
WEBSITE	longtermcare.wi.gov

SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Wisconsin, the Quality Improvement Organization is called Livanta BFCC-QIO Program.

Livanta BFCC-QIO Program has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta BFCC-QIO Program is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO Program in any of these situations:

- You have a complaint about the quality of care you have received.
- 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 are ending too soon.

Method	Livanta BFCC-QIO Program (Wisconsin's Quality Improvement Organization)
CALL	888-524-9900 Available Monday – Friday from 9 a.m. to 5 p.m. Saturday, Sunday and federal holidays from 11 a.m. to 3 p.m.
TTY	888-985-8775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	livantaqio.com/en/states/wisconsin

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older or who have a disability or ESRD and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available Monday – Friday from 7 a.m. to 7 p.m. You can 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 with hearing or speaking. Calls to this number are free. Available Monday – Friday from 7 a.m. to 7 p.m.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid
(a joint federal and state program that helps with medical costs for some people with limited income and resources)

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **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.
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Wisconsin Medicaid.

Method	Wisconsin Medicaid – Contact Information
CALL	1-800-362-3002 Available Monday – Friday from 8 a.m. to 6 p.m.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Department of Health Services 1 West Wilson St. Madison, WI 53703
WEBSITE	dhs.wisconsin.gov/medicaid

SECTION 7 How to contact the Railroad Retirement Board

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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative Monday, Tuesday, Thursday and Friday from 9 a.m. to 3:30 p.m. and Wednesday from 9 a.m. to 12 p.m. If you press "1", you may access the automated RRB HelpLine and 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 with hearing or speaking. Calls to this number are *not* free.
WEBSITE	https://rrb.gov/

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or our member experience team if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums or the enrollment period. (Phone numbers for our member experience team are printed on the back cover of this booklet.)

You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

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SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are "in-network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"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.
- **"In-network providers"** are the doctors and other health care professionals, medical groups, hospitals and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see an in-network provider, you pay only your share of the cost for their services.
- **"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 benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

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

Network Platinum*Plus* will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered 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.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either an in-network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
    - The providers in our network are listed in the *Provider Directory*.

- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using in-network and out-of-network providers to get your medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

- The role of your PCP, also known as your ***personal doctor***, is to provide routine, preventive and follow up care and to coordinate your care when you see a specialist or other provider. This includes checking or consulting with the specialist or other providers you've seen about how your care is going. Since your PCP can provide and coordinate your medical care, you may choose to have all your past medical records sent to your PCP's office. If you need certain types of services, your PCP may need to get prior authorization (prior approval) from Network Platinum*Plus* if that service is received from an in-network provider. Out-of-network providers and services do not require prior authorization. For services requiring a prior authorization please see Chapter 4, section 2.1 or visit your online member portal at login.networkhealth.com.

- It is very important to have a PCP. Your PCP can be a physician, physician assistant, or nurse practitioner in the specialty areas of internal medicine, family practice or pediatrics who sees patients in a clinic or office.

How do you choose your PCP?

Selecting a primary care physician (PCP) is important. If you have a PCP or would like to designate a PCP, please share this information with our member experience team by calling the number on your member ID card or visit your online member portal at login.networkhealth.com. If you do not have a PCP or are not sure who to select as your PCP, Network Health will assign one to you.

If you do not currently have a PCP, wish to make a change and would like assistance in finding one, our member experience team can assist you, you can look at your *Provider Directory* to choose a provider or you can use the website at networkhealth.com/find-a-doctor to see and select from the complete list of providers who are available and meet the qualifications to serve as your PCP.

Whether your PCP is selected or assigned, you'll receive the same high-quality care, and Network Platinum*Plus* will communicate with your PCP to help coordinate your care.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

If you would like assistance with finding a new PCP, our member experience team can assist you, you can look at your *Provider Directory* to choose a provider or you can use the website at networkhealth.com/find-a-doctor to see a complete list of providers available. If you have changed your PCP, please share this information with our member experience team or update your online member portal at login.networkhealth.com.

Section 2.2 How to get care from specialists and other in-network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint or muscle conditions.
- Although, a specialist may require a referral, Network Platinum*Plus* does not require a referral from your PCP when obtaining services from any specialists or other plan professionals in- or out-of-network. You can call the specialist's office directly or your PCP can help you coordinate the specialist visit. You are not limited to specialists or hospitals to which your PCP refers you to; but if the specialist or hospital is out-of-network, you may have a higher cost-sharing amount.

If you need certain types of services, your PCP or specialist may need to get prior authorization (approval in advance) from Network Platinum*Plus* if that service is rendered in-network. Out-of-network providers and services do not require prior authorization. For services requiring a prior authorization please see Chapter 4, Section 2.1 or visit your online member portal at login.networkhealth.com.

What if a specialist or another in-network provider leaves our plan?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new, qualified provider to continue managing your health care needs.

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.

You can refer to your *Provider Directory*, call our member experience team (phone number is on the back cover of this booklet) or visit our website at networkhealth.com/find-a-doctor for help in finding a new provider.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint)* to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.

- If you are using an out-of-network provider for emergency care, urgently needed services or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

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, 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 is 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 do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that 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.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

When Emergency Care is received **outside the United States and its territories (worldwide coverage)** you will be responsible for $90 per incident. Network Platinum*Plus* will pay the remaining cost per incident up to the maximum of $100,000 every year. Prescription drugs are not covered. For more information, see the Medical Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers who do not accept Medicare, we will try to arrange for in-network providers to take

over your care as soon as your medical condition and the circumstances allow. If you get your follow-up care from out-of-network providers, you may pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get care from in-network providers or out-of-network providers. If you get care from in-network providers, your share of the costs will usually be lower than if you get care from out-of-network providers.

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care.

However, if the circumstances are unusual or extraordinary, and in-network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

Urgent care centers and walk-in-clinics are often open on nights and weekends. You can find participating urgent care providers by looking at our online *Provider Directory* at networkhealth.com/find-a-doctor. Click find a doctor, click find a facility and choose Urgent Care Services. You may also call our member experience team (phone numbers are located on the back cover of this booklet) if you need assistance locating an urgent care provider.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from an in-network provider, our plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

Our plan covers worldwide urgent care services outside the United States under the following circumstances. When Urgent Care is received **outside the United States and its territories (worldwide coverage)** you will be responsible for $90 per incident. Network Platinum*Plus* will pay the remaining cost

per incident up to the maximum of $100,000 every year. Prescription drugs are not covered. For more information, see the Medical Benefits Chart in Chapter 4.

Section 3.3 Getting 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 are still entitled to care from your plan.

Please visit the following website: networkhealth.com for information on how to obtain needed care during a disaster.

Generally, if you cannot use an in-network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Network Platinum*Plus* covers all medical services that are medically necessary, these services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet) and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

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

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call our member experience team to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used 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.

SECTION 5 How are your medical services covered when you are 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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

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. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact our member experience team (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive 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 is part of the research study
- Treatment of side effects and complications of the new care

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is 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 will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 Receiving 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 are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is *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's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Medicare inpatient hospital coverage limits apply. Please see the benefits chart in Chapter 4 for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as 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 use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that 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 Platinum*Plus*, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call our member experience team (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while on our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Network Platinum*Plus* 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 Platinum*Plus* or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is 20 percent of the cost, every month for 36 months.

Once the 36-month rental payment cap for the oxygen equipment has been reached, your cost sharing ends. 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 (i.e., five years) or as long as you have a medical need for the oxygen. If you still need the equipment (i.e., you meet the medical necessity for the oxygen) after the five year reasonable useful lifetime of the equipment has been reached, a new capped rental period may begin

If prior to enrolling in Network Platinum*Plus* you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Network Platinum*Plus* is 0 percent.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining Network Platinum*Plus*, join Network Platinum*Plus* for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in Network Platinum*Plus* and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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Network Platinum*Plus* will comply with all federal coverage requirements relating to the COVID-19 pandemic and may provide additional benefits depending upon the duration of the health emergency. If there are additional benefits added to your plan we will notify you. If you have questions once we notify you, please contact our member experience team for further details (phone numbers are printed on the back cover of this booklet).

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Network Platinum*Plus*. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact our member experience team.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $3,400. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from in-network providers. The amounts you pay for copayments and coinsurance for covered services from in-network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,400 for covered Part A and Part B services from in-network providers, you will not have any out-of-pocket costs for the rest of the year when you see

in-network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $3,400. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, the amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you have paid $3,400 for covered services, you will have 100 percent coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of Network Platinum*Plus*, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from an in-network provider. You will generally have higher copayments when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from an in-network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call our member experience team (phone numbers are printed on the back cover of this booklet.)

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Network Platinum*Plus* covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies and equipment) *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.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other in-network provider gets approval in advance (sometimes called "prior authorization") from Network Platinum*Plus*.
    - Covered services that need approval in advance to be covered as in-network services are marked in italics in the Medical Benefits Chart. In addition, the following services not listed in the Benefits Chart require approval in advance:
        - Hospital inpatient services, behavioral health inpatient services and skilled nursing facility stays including sub-acute and swing bed
        - Transplant services
        - Specialty surgeries such as ankle, knee, hip and shoulder joint replacements, bariatric surgery, deep brain stimulator insertion, sleep apnea and all procedures that could be considered cosmetic
        - Certain durable medical equipment such as wheelchairs, orthotics, and prosthetics and electrical stimulators
        - Outpatient radiation oncology services
        - Outpatient interventional pain injections and procedures
        - Non-emergent ambulatory injectable chemotherapy drugs
        - Certain medications under your medical benefit
        - Genetic testing
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:

- If you receive the covered services from an in-network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
- If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
- If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- 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.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.).
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. **However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition**.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The 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.	**In-Network** There is no coinsurance, copayment or deductible for members eligible for this preventive screening. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries 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, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those 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.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$40** copayment for each Medicare-covered acupuncture treatment. **Out-of-Network** $40 copayment for each Medicare-covered acupuncture treatment.

Services that are covered for you	**What you must pay** when you get these services
Ambulance services • Covered ambulance services include fixed wing, rotary wing and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is 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: o You decline the ambulance ride o You take the ambulance and it is determined your symptoms are not emergent	Cost sharing for covered services applies toward the annual out-of-pocket maximum. Cost sharing applies to each one-way transport. **In-Network** **$250** copayment for each Medicare-covered ground or air ambulance trip. **Out-of-Network** **$250** copayment for each Medicare-covered ground or air ambulance trip.

Services that are covered for you	**What you must pay** when you get these services
Annual Routine Preventive Physical Exam Non-Medicare covered routine physical exams are covered once every 12 months. This Comprehensive physical must include a preventive medicine evaluation and management, including an age and gender appropriate history, examination and counseling/anticipatory guidance/risk factor reduction interventions. You are able to have lab screening for early detection of diabetes, high cholesterol or blood disorders. As part of your Annual wellness visit **OR** your Annual Routine Preventive Physical Exam you can have a fasting blood sugar, lipid panel and/or complete blood count included in the cost. **Note:** These screening labs are to assist in early detection of new health conditions, not as part of routine monitoring of existing health conditions. **Note:** If you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$0** copayment for the non-Medicare covered routine physical exam. **Out-of-Network** **$0** copayment for the non-Medicare covered routine physical exam.

Services that are covered for you	**What you must pay** when you get these 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. You can have lab screening for early detection of diabetes, high cholesterol or blood disorders. As part of your Annual wellness visit **OR** your Annual Routine Preventive Physical Exam you can have a fasting blood sugar, lipid panel and/or complete blood count included in the cost. **Note:** These screening labs are to assist in early detection of new health conditions not as part of routine monitoring of existing health conditions. Medicare covers voluntary Advance Care Planning as part of the yearly wellness visit. This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your health care professional, and he or she can help you fill out the forms, if you want to. An advance directive is a legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care. You pay nothing if the doctor or other qualified health care provider accepts assignment. **Note:** Medicare may also cover this service as part of your medical treatment. When Advance Care Planning isn't part of your Annual wellness visit, the Part B deductible and coinsurance apply. **Note:** If you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.	**In-Network** There is no coinsurance, copayment or deductible for the annual wellness visit. **$0** copayment for lipid profile, fasting blood sugar and complete blood count if provided as part of the annual wellness visit if it is done for preventive screening not for treatment or disease monitoring. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit. **$0** copayment for lipid profile, fasting blood sugar and complete blood count if provided as part of the annual wellness visit if it is done for preventive screening not for treatment or disease monitoring.

Services that are covered for you	**What you must pay** when you get these services
Bone mass measurement For qualified individuals (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: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network** There is no coinsurance, copayment or deductible for Medicare-covered bone mass measurement. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
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 age 40 and older • Clinical breast exams once every 24 months **Note:** 3D mammogram is only covered when done in conjunction (at the same time) with a screening or diagnostic 2D mammogram. 3D does not have any extra cost to the member. **Note:** A screening mammography is used for the early detection of breast cancer in women who have no signs or symptoms of the disease. Once a history of breast cancer has been established, and until there are no longer any signs or symptoms of breast cancer, ongoing mammograms are considered diagnostic and are subject to cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. Therefore, the screening mammography annual benefit is not available for members who have signs or symptoms of breast cancer.	**In-Network** There is no coinsurance, copayment or deductible for covered screening mammograms. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these 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. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$25** copayment for each Medicare-covered cardiac rehabilitation, intensive cardiac rehabilitation or Peripheral Arterial Disease (PAD) rehabilitation. **Out-of-Network** **$25** copayment for each Medicare-covered cardiac rehabilitation, intensive cardiac rehabilitation or Peripheral Arterial Disease (PAD) rehabilitation**.**
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.	**In-Network** There is no coinsurance, copayment or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	**In-Network** There is no coinsurance, copayment or deductible for cardiovascular disease testing that is covered once every five years. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these 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 are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	**In-Network** There is no coinsurance, copayment or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
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.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. You pay 100% for maintenance care. **In-Network** **$20** copayment for each Medicare-covered chiropractic visit. **Out-of-Network** **$20** copayment for each Medicare-covered chiropractic visit.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every three years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every ten years (120 months), but not within 48 months of a screening sigmoidoscopy. **Note:** A screening colonoscopy is used for the diagnosis and/or early detection of colorectal cancer in people who have no signs or symptoms of the disease. Once a history of colorectal cancer has been established, and until there are no longer any signs or symptoms of colorectal cancer, ongoing colonoscopies are considered diagnostic and are subject to cost sharing as described under Outpatient Surgery in this chart. **Therefore, the screening colonoscopy benefit is subject to the Outpatient Surgery cost sharing for members who have signs or symptoms of colorectal cancer**. **Note: A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the Outpatient Surgery cost sharing described later in this chart**.	**In-Network** There is no coinsurance, copayment or deductible for a Medicare-covered colorectal cancer screening exam. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Predeterminations are recommended for all dental services. **Medicare-covered dental services include:** Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a physician. As a member of this plan, you have the option of purchasing an optional supplemental dental benefit package for comprehensive dental services. See Chapter 4, Section 2.2 for more information.	Cost sharing for covered services applies toward the annual out-of-pocket maximums. **In-Network** **$25** copayment for each Medicare-covered dental service. **Out-of-Network** **$25** copayment for each Medicare-covered dental service.
Dental services – additional benefits We cover preventive dental services not covered by Original Medicare. We cover: • One non-Medicare covered oral exam and one non-Medicare covered cleaning per year. * The plan pays a maximum of $100 for your covered preventive dental services. **Note:** Our provider network for non-Medicare covered dental services is different than our provider network for medical dental services. Your preventive dental services are administered by Delta Dental Medicare Advantage. For a link to the provider search and the dental certificate, visit networkhealth.com/medicare/additional-benefits. You can also request a hard copy of the dental certificate by calling our member experience team. If you receive services from a Dentist that has affirmatively opted not to participate with Medicare, Delta Dental will be unable to make any payments to either you or your Dentist and you will be responsible for all costs. Prior to receiving services from your Dentist, you should confirm whether or not your Dentist has affirmatively opted out of Medicare participation. As a member of the plan, you have the option of purchasing an optional supplemental dental benefit package for comprehensive dental services. See Chapter 4, Section 2.2 for more information.	**In-Network** **$30** copayment for one non-Medicare covered oral exam and cleaning. **Out-of-Network** Reimbursement up to a maximum of **$100** for one non-Medicare covered oral exam and cleaning.

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

Services that are covered for you	**What you must pay** when you get these services
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.	**In-Network** There is no coinsurance, copayment or deductible for an annual depression screening visit. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following 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.	**In-Network** There is no coinsurance, copayment or deductible for the Medicare-covered diabetes screening tests. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these 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: Accu-Chek or OneTouch blood glucose monitor, Accu-Chek or OneTouch blood glucose test strips, covered lancet devices, covered lancets, and covered 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 (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 at no cost. Preferred devices are FreeStyle Libre and Dexcom.	**In-Network** **$0** copayment for beneficiaries eligible for diabetes self-management training. **$0** copayment for Accu-Chek or OneTouch test strips and each covered diabetic supply item up to a 90-day supply. **$0** copayment for FreeStyle Libre and Dexcom supplies. **$10** copayment for each pair of Medicare-covered diabetic therapeutic shoes or inserts. **Out-of-Network** **$0** copayment for beneficiaries eligible for diabetes self-management training. **$0** copayment for Accu-Chek or OneTouch test strips and each covered diabetic supply item up to a 90-day supply. **$0** copayment for FreeStyle Libre and Dexcom supplies. **$10** copayment for each pair of Medicare-covered diabetic therapeutic shoes or inserts.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," Chapter 10 of this booklet.) Covered items include, but are not 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. Most DME requires a prior authorization. If our supplier in your area does not carry a particular brand or manufacturer, you may 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 agreement 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 Platinum*Plus*, 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 oxygen- after the five year reasonable useful lifetime of the equipment has been reached, a new capped rental period may begin. **Note**: DME purchased at a retail store is not a covered benefit. If you have questions about your medical costs or have received DME when you travel, please call our member experience team.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **20%** of the cost for each Medicare-covered durable medical service or item. **Out-of-Network** **20%** of the cost for each Medicare-covered durable medical service or item.

Services that are covered for you	**What you must pay** when you get these services
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 you have medical symptoms that require immediate medical attention to prevent loss of life, 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 is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you are admitted as an inpatient within 24 hours for the same condition, you pay $0 for emergency room visit. When Emergency care is received **outside the United States and its territories (worldwide coverage)**, you will be responsible for $90 per incident. Network Platinum*Plus* will pay the remaining cost per incident up to the maximum $100,000 every year. Some facilities may bill Network Health directly, and this is the preferred method, using U.S. dollars. Other facilities may require you to pay the full cost of your care, and you will need to ask us to reimburse you for your costs. In this situation, you will be required to provide documents that may include a copy of the bill, proof of payment and English-language medical records (charges should be converted to U.S. dollars) for reimbursement up to the maximum of $100,000. Prescription drugs are not covered. *	Cost sharing for covered services within the United States and its territories applies toward the annual out-of-pocket maximum. **In-Network** **$120** copayment each Medicare-covered emergency room visit within the United States and its territories. **$90** per incident for each non-Medicare covered emergency room visit outside the United States and its territories. **Out-of-Network** **$120** copayment each Medicare-covered emergency room visit within the United States and its territories. **$90** per incident for each non-Medicare covered emergency room visit outside the United States and its territories.

* Cost sharing for covered services outside the United States and its territories (worldwide coverage) *does not* apply toward the annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services
Fitness program Your fitness program includes access to more than 16,000 locations nationwide, at-home fitness kits and fitness classes for all levels. Visit networkhealth.com for more information.	**In-Network** **0%** of the cost when visiting participating fitness facilities. **Out-of-Network** When going to a non-contracted health club facility, fitness center membership charges will apply. We do not reimburse for these fees.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	Cost sharing for Medicare-covered services apply toward the annual out-of-pocket maximum. **In-Network** **$25** copayment for each Medicare-covered hearing exam. **Out-of-Network** **$25** copayment for each Medicare-covered hearing exam.
Hearing services – additional benefits As an additional benefit, you have access to select hearing aids at discounted prices when you see a participating provider. Qualifying hearing aids from a participating provider are discounted to $795 - $2,370 per hearing aid. * **Note:** Our provider network for hearing aid discounts is different than our provider network for medical hearing services. Hearing aid services are administered by Simpli Hearing, LLC. For more information and a link to the provider search, visit networkhealth.com/medicare/additional-benefits.	Hearing aids purchased through Simpli Hearing, LLC. will be discounted to $795 - $2,370 per hearing aid.

* Your costs for hearing aids *does not* apply toward the annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services

Help with Certain Chronic Conditions
• Acupuncture
  ○ As an alternative to nausea medications, a maximum of 12 visits per year are covered for members who are undergoing chemotherapy.
• Transportation
  ○ Includes 24 one-way trips per year for members diagnosed with End-Stage Renal Disease to get to and from dialysis for treatment. Trips must be booked through our approved vendor "Aryv".
• Home-Based Palliative Care Consultation and Evaluation for members with an end-stage (Stage 4) cancer diagnosis
  ○ Care managers will coordinate a PCP or Oncologist referral to a hospice home care provider for a palliative care consult. At this visit, hospice home care personnel provide an in-home palliative care consultation and evaluation.
	In-Network
	$0 copayment for each acupuncture treatment.
	$0 copayment for each one-way transportation for dialysis treatment.
	$0 copayment for each home-based palliative care consultation and evaluation.
	Out-of-Network
	$0 copayment for each acupuncture treatment.
	$0 copayment for each one-way transportation for dialysis treatment.
	$0 copayment for each home-based palliative care consultation and evaluation.

HIV screening For people who ask for an HIV screening test or who 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	**In-Network** There is no coinsurance, copayment or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Home health agency care Prior to receiving 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 are not 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 o Physical, occupational and speech therapy services provided by an outpatient provider while you are receiving any home care services are not covered unless the home care agency agrees to cover the cost of the outpatient therapies. • Medical and social services • Medical equipment and supplies	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$0** copayment for Medicare-covered home health visit. **Out-of-Network** **$0** copayment for Medicare-covered home health visit.

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual 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 are not 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 provisions of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Note: If additional services are performed and the cost sharing for those services is not listed here, they will be subject to the cost sharing described elsewhere in this chart.	**In-Network** **$0** copayment for Medicare-covered home health visit. **20%** of the cost for each Medicare-covered Part B drug. **20%** of the cost for each Medicare-covered durable medical service or item. **Out-of-Network** **$0** copayment for Medicare-covered home health visit. **20%** of the cost for each Medicare-covered Part B drug. **20%** of the cost for each Medicare-covered durable medical service or item.

Services that are covered for you	**What you must pay** when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. You are 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. Your hospice doctor can be an in-network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from an in-network provider, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost sharing for out-of-network services. For services that are covered by Network Platinum*Plus* but are not covered by Medicare Part A or B: Network Platinum*Plus* will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. Continued on the next page	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 Platinum*Plus*. **In-Network** **$0** copayment for hospice consultation. **Out-of-Network** **$0** copayment for hospice consultation.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (continued) **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our in-network providers will lower your share of the costs for the services. **Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.**	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rule, such as: ○ Tetanus, diphtheria and pertussis (T-DAP) when related to the **treatment of an injury** or **direct exposure** to a disease or condition **Note:** Vaccines for shingles, tetanus/diphtheria/pertussis prevention and travel are not covered under this plan.	**In-Network** There is no coinsurance, copayment or deductible for the pneumonia, influenza and hepatitis B vaccines. **$0** copayment for all other Medicare Part B covered immunizations. **Out-of-Network** There is no coinsurance, copayment or deductible for the pneumonia and influenza vaccines. **$0** copayment for hepatitis B and all other Medicare Part B covered immunizations.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services Continued on the next page	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **Per admission you pay** **In-Network** *All hospital inpatient services, including medical, surgical, behavioral health and rehabilitation require that your provider notify us in advance.*

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • 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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Network Platinum*Plus* provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Facilities located within the Network Platinum*Plus* 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. o 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 o Lodging and reimbursement is limited to the United States General Services Administration per diem rate Continued on the next page	*Please have your provider contact the plan for more details.* **$175** copayment per day for days 1-5 of a Medicare-covered inpatient hospital stay. **$0** copayment per day for all other days of a Medicare-covered inpatient hospital stay. There is no limit to the number of days covered. **Out-of-Network** **$175** copayment per day for days 1-5 of a Medicare-covered inpatient stay in a hospital. **$0** copayment per day for all other days of a Medicare-covered stay in a hospital. There is no limit to the number of days covered. Your inpatient cost share will begin on day one each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Long Term Acute Care (LTAC) facilities and Inpatient Acute Care facilities. 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 get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) o Mileage reimbursement is limited to the Internal Revenue Service medical rate o Only the following types of travel expenses are reimbursable; auto mileage, economy class airfare, train fare, parking, tolls, shuttle/bus fare **Note:** Only the cost of transportation between the member's residence located in the Network Platinum*Plus* service area to the designated transplant facility is reimbursable. You will be reimbursed for traveling and lodging only if all these criteria are met: ▪ Network Platinum*Plus* directs you to a facility that is outside the normal community patterns of care ▪ You choose to go to the directed facility for the transplant ▪ You submit all necessary documentation (such as receipts, lodging verifications, etc.) to this address: Network Health Medicare Advantage Plans PO Box 120 1570 Midway Pl. Menasha, WI 54952 • 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 • Physician services. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. If you stay in the hospital overnight, you might still be considered an outpatient. In addition, your hospital status affects how much you pay for hospital services. • You're an inpatient starting 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. Continued on the next page	

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (continued) • You're an outpatient if you're receiving emergency department services, observation services, outpatient surgery, lab tests or x-rays and the doctor **hasn't** written an order to admit you to the hospital as an inpatient. In these cases, you're an outpatient even if you spend the night in the hospital. **Note:** Observation services are hospital outpatient services performed 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. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available online at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, seven days a week.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care 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 does not apply to the mental health services provided in psychiatric unit of a general hospital	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **Per admission you pay** **In-Network** *Except in an emergency, your doctor must tell the plan you are going to be admitted to the hospital.* *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$150** copayment per day for days 1-10 of a Medicare-covered inpatient psychiatric stay. **$0** copayment per day for days 11-90 of a Medicare-covered inpatient psychiatric stay, including lifetime reserve days. Lifetime reserve days can only be used once. **Out-of-Network** **$150** copayment per day for days 1-10 of a Medicare-covered inpatient psychiatric stay. **$0** copayment per day for days 11-90 of a Medicare-covered inpatient psychiatric stay, including lifetime reserve days. Lifetime reserve days can only be used once.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or skilled nursing facility during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not 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; 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	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$15** copayment for each Medicare-covered PCP visit. **$40** copayment for each Medicare-covered specialist visit. **$0** to **$5** copayment for each Medicare-covered diagnostic procedure, test and/or lab service. Specific low-cost lab services including routine venipuncture, routine glycosylated hemoglobin test (HbA1c) and urinalysis without scope are performed at a $0 copayment. All other lab services will fall under the $5 copayment. **$25** copayment for each Medicare-covered x-ray, ultrasound, EKG, EEG, echocardiogram or stress test. **$60** copayment for each Medicare-covered radiation therapy service. **$100** copayment for each Medicare-covered diagnostic radiology, PET, CAT, MRI, MRA and NUC service. **20%** of the cost for each Medicare-covered prosthetic, orthotic device or durable medical equipment.

Continued on the next page

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or skilled nursing facility during a non-covered inpatient stay (continued)	**$40** copayment for each Medicare-covered physical therapy, speech therapy, occupational therapy visit. **Out-of-Network** **$15** copayment for each Medicare-covered PCP visit. **$40** copayment for each Medicare-covered specialist visit. **$0 to $5** copayment for each Medicare-covered diagnostic procedure, test and/or lab service. Specific low-cost lab services including routine venipuncture, routine glycosylated hemoglobin test (HbA1c) and urinalysis without scope are performed at a $0 copayment. All other lab services will fall under the $5 copayment. **$25** copayment for each Medicare-covered x-ray, ultrasound, EKG, EEG, echocardiogram or stress test. **$60** copayment for each Medicare-covered radiation therapy service. **$100** copayment for each Medicare-covered diagnostic radiology, PET, CAT, MRI, MRA and NUC service. **20%** of the cost for each Medicare-covered prosthetic, orthotic device or durable medical equipment. **$40** copayment for each Medicare-covered physical therapy, speech therapy and occupational therapy visit.

Services that are covered for you	**What you must pay** when you get these 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 your first year that you receive 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 condition, treatment or diagnosis changes, you may be able to receive 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.	**In-Network** There is no coinsurance, copayment or deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries 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.	**In-Network** There is no coinsurance, copayment or deductible for the MDPP benefit. **Out-of-Network** **$0** copayment for the MDPP benefit.

Services that are covered for you	**What you must pay** when you get these services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive 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 are getting physician, hospital outpatient or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. The following link will take you to a list of Part B drugs that may be subject to step therapy: networkhealth.com/medicare/pharmacy-information. We also cover some vaccines under our Part B prescription drug benefit.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. Certain Part B prescription drugs may require step therapy. In addition to the Part B prescription drug cost sharing amount, you may also pay the cost sharing amount that applies to primary care provider services, specialist services or outpatient hospital services, depending on where the Part B prescription drug is administered. **In-Network** *Medicare Part B and Part B chemotherapy medications given in the physician's office require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **20%** of the cost for each Medicare-covered Part B and Chemotherapy drug. **Out-of-Network** **20%** of the cost for each Medicare-covered Part B and Chemotherapy drug.

Services that are covered for you	**What you must pay** when you get these services
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.	**In-Network** There is no coinsurance, copayment or deductible for preventive obesity screening and therapy. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$35** copayment for each Medicare-covered opioid treatment program service **Out-of-Network** **$35** copayment for each Medicare-covered opioid treatment program service.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not 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 Continued on the next page	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Pain management services, hip, knee and shoulder procedures, may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$0 to $5** copayment for each Medicare-covered diagnostic procedure, test and/or lab service. Specific low-cost lab services including routine venipuncture,

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies (continued) • 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 • Diagnostic mammograms • Other outpatient diagnostic tests	routine glycosylated hemoglobin test (HbA1c) and urinalysis without scope are performed at a $0 copayment. All other lab services will fall under the $5 copayment. **$25** copayment for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test. **$25** copayment for each Medicare-covered x-ray service or diagnostic mammogram. **$60** copayment for each Medicare-covered radiation therapy. **$100** copayment for each Medicare-covered diagnostic radiology MRI, MRA, PET, CAT or NUC service. **Out-of-Network** **$0 to $5** copayment for each Medicare-covered diagnostic procedure, test and/or lab service. Specific low-cost lab services including routine venipuncture, routine glycosylated hemoglobin test (HbA1c) and urinalysis without scope are performed at a $0 copayment. All other lab services will fall under the $5copayment. **$25** copayment for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test. **$25** copayment for each Medicare-covered x-ray service or diagnostic mammogram. **$60** copayment for each Medicare-covered radiation therapy. **$100** copayment for each Medicare-covered diagnostic radiology MRI, MRA, PET, CAT or NUC service.

Services that are covered for you	**What you must pay** when you get these 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 the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available online at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, seven days a week.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$350** copayment for each Medicare-covered outpatient hospital observation service. **Out-of-Network** **$350** copayment for each Medicare-covered outpatient hospital observation service.
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 are not 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 that you can't give yourself Continued on the next page	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services including some outpatient surgeries may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$0 to $5** copayment for each Medicare-covered diagnostic procedure, test and/or lab service. Specific low-cost lab services including routine venipuncture, routine glycosylated hemoglobin

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued) **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available online at www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, seven days a week.	test (HbA1c) and urinalysis without scope are performed at a $0 copayment. All other lab services will fall under the $5 copayment. **$25** copayment for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test. **$25** copayment for each Medicare-covered x-ray or diagnostic mammogram service. **$60** copayment for each Medicare-covered radiation therapy. **$100** copayment for each Medicare-covered diagnostic radiology MRI, MRA, PET, CAT or NUC service. **20%** of the cost for each Medicare-covered Part B and chemotherapy drug. **$350** copayment for each Medicare-covered outpatient hospital visit. **Out-of-Network** **$0 to $5** copayment for each Medicare-covered diagnostic procedure, test and/or lab service. Specific low-cost lab services including routine venipuncture, routine glycosylated hemoglobin test (HbA1c) and urinalysis without scope are performed at a $0 copayment. All other lab services will fall under the $5 copayment. **$25** copayment for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test.

Continued on the next page

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services (continued)	**$25** copayment for each Medicare-covered x-ray or diagnostic mammogram service. **$60** copayment for each Medicare-covered radiation therapy. **$100** copayment for each Medicare-covered diagnostic radiology MRI, MRA, PET, CAT, or NUC service. **20%** of the cost for each Medicare-covered Part B and Chemotherapy drug. **$350** copayment for each Medicare-covered outpatient hospital visit.
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, nurse practitioner, physician assistant or other Medicare-qualified mental health care professional as allowed under applicable state laws. Prior review of the program may be required before the provider furnishes services.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$35** copayment for each Medicare-covered outpatient mental health individual or group therapy visit. **Out-of-Network** **$35** copayment for each Medicare-covered outpatient mental health individual or group therapy visit.

Services that are covered for you	**What you must pay** when you get these services
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).	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$40** copayment for each Medicare-covered occupational therapy, physical therapy and speech and language therapy visit. **Out-of-Network** **$40** copayment for each Medicare-covered occupational therapy, physical therapy and speech and language therapy visit.
Outpatient substance abuse 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.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. You pay 100% for third party requests or required (i.e. employment, foster grandparent or court ordered) physicals, exams and related services. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$20** copayment for each Medicare-covered individual or group therapy substance abuse visit. **Out-of-Network** **$20** copayment for each Medicare-covered individual or group therapy substance abuse visit.

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are 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.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$350** copayment for each Medicare-covered ambulatory surgical center visit and outpatient hospital visit. **Out-of-Network** **$350** copayment for each Medicare-covered ambulatory surgical center visit and outpatient hospital visit.
Over-the-counter (OTC) items Our plan offers a $50 allowance per quarter, to be used to purchase qualified over-the-counter (OTC) items from our mail order service. Your $50 quarterly benefit will be available at the beginning of each quarter of the calendar year (January, April, July and October). Maximum of one order per quarter. Unused funds will expire at the end of each quarter. OTC services are administered by Express Scripts, Inc. For more information on how to use your $50 quarterly allowance, visit networkhealth.com/medicare/additional-benefits or log into the member portal at login.networkhealth.com.	**In-Network** **0%** of the cost of qualified OTC items, up to the $50 quarterly maximum. **Out-of-Network** OTC items must be ordered from the plan's approved service. We do not reimburse for OTC items purchased from retail stores or other mail order services.

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization 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 is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$40** copayment for each Medicare-covered partial hospitalization services. **Out-of-Network** **$40** copayment for each Medicare-covered partial hospitalization services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department or any other location • Consultation, diagnosis and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: PCP office visit, specialist office visit, and outpatient mental health individual or group therapy. o You have the option of getting these services through an in-person visit or by telehealth. Both the in-person and telehealth visit are subject to a copayment, which is based on the type of visit. If you choose to get one of these services by telehealth, **you must use a network provider** who offers the service by telehealth. Continued on the next page	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$15** copayment for each Medicare-covered PCP office visit. **$40** copayment for each Medicare-covered specialist office visit. **$25** copayment for each Medicare-covered hearing exam. **$25** copayment for each Medicare-covered dental service. **Out-of-Network** **$15** copayment for each Medicare-covered PCP office visit. **$40** copayment for each Medicare-covered specialist office visit. **$25** copayment for each Medicare-covered hearing exam.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (continued) o These services are available by phone, smartphone, tablet and/or computer. Please check with your provider for which device is needed and if other devices are required o 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 o Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • 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 and 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** 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 and office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet or electronic health record **if** you're not a new patient • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease or services that would be covered when provided by a physician)	**$25** copayment for each Medicare-covered dental service.

Services that are covered for you	**What you must pay** when you get these 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	Cost sharing for covered services applies toward the annual out-of-pocket maximum. You pay 100% for nail trimming unless performed as a qualified diabetic service. **In-Network** **$40** copayment for each Medicare-covered podiatry visit. **Out-of-Network** **$40** copayment for each Medicare-covered podiatry visit.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-Network** There is no coinsurance, copayment or deductible for an annual PSA test. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to, 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 devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **20%** of the cost for each Medicare-covered item. **Out-of-Network** **20%** of the cost for each Medicare-covered item.

Services that are covered for you	**What you must pay** when you get these 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.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$25** copayment for each Medicare-covered pulmonary rehabilitation service. **Out-of-Network** **$25** copayment for each Medicare-covered pulmonary rehabilitation service.
Remote access care resources Your plan covers many ways to get care quickly, any time of the day or night. Our programs offer instant access to live health care resources that provide helpful information you can trust. **Visit networkhealth.com/wellness/getting-care-quickly to learn more about your resources.**	**In-Network** **0%** of the cost for these services. **Out-of-Network** **0%** of the cost for these services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (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.	**In-Network** There is no coinsurance, copayment or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written 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 member must receive a written 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 subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network** There is no coinsurance, copayment or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
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 will 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.	**In-Network** There is no coinsurance, copayment or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.

Services that are covered for you	**What you must pay** when you get these 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) • Inpatient dialysis treatments (if you are 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 your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section, "Medicare Part B prescription drugs."	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** *Services may require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$0** copayment for Medicare-covered kidney disease education services. **20%** of the cost for each Medicare-covered renal dialysis. **20%** of the cost for each Medicare-covered durable medical service or item. **Out-of-Network** **$0** copayment for Medicare-covered kidney disease education services. **20%** of the cost for each Medicare-covered renal dialysis. **20%** of the cost for each Medicare-covered durable medical service or item.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing service • 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 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 • Medical and surgical supplies ordinarily provided by skilled nursing facilities • Laboratory tests ordinarily provided by skilled nursing facilities • X-rays and other radiology services ordinarily provided by skilled nursing facilities • Use of appliances such as wheelchairs ordinarily provided by skilled nursing facilities • Physician/practitioner services Generally, you will get your skilled nursing facility care from in-network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't an in-network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A skilled nursing facility where your spouse is living at the time you leave the hospital You are covered for up to 100 days per admission. (Facility transfers are not considered a "new" admission.)	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **Per admission you pay** **In-Network** *All skilled nursing facility stays including sub-acute and swing bed require that your provider get prior authorization (approval in advance). Please have your provider contact the plan for more details.* **$20** copayment per day, days 1-20 for Medicare-covered skilled nursing facility stay. **$184** copayment per day, days 21-54 for Medicare-covered skilled nursing facility stay. **$0** copayment per day, days 55-100 for Medicare-covered skilled nursing facility stay. **Out-of-Network** **$20** copayment per day, days 1-20 for Medicare-covered skilled nursing facility stay. **$184** copayment per day, days 21-54 for Medicare-covered skilled nursing facility stay. **$0** copayment per day, days 55-100 for a Medicare-covered skilled nursing facility stay.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12 month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits.	**In-Network** There is no coinsurance, copayment or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network** **$0** copayment for beneficiaries eligible for this preventive benefit.
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.	Cost sharing for covered services applies toward the annual out-of-pocket maximum. **In-Network** **$25** copayment for each Medicare-covered supervised exercise therapy session. **Out-of-Network** **$25** copayment for each Medicare-covered supervised exercise therapy session.

Services that are covered for you	**What you must pay** when you get these services
Telemonitoring*	**In-Network**
Telemonitoring is available for members diagnosed with chronic or congestive heart failure.	**0%** of the cost for non-Medicare covered telemonitoring services.
Interventions include telephone-based symptom monitoring, automated monitoring of signs and symptoms and/or automated physiologic monitoring and education from nurses trained in heart failure management. The objectives are to monitor and manage symptoms, adherence to diet and medications, optimal fluid status and daily physical activity.	**Out-of-Network**
You will be able to enter data at least weekly to an electronic communication device, downloaded to a secure website reviewed by clinicians. You will be trained to transmit the data properly. All devices must comply with applicable state and federal requirements. The home health care agency must implement a plan of care based on any findings. The managing provider (PCP or specialty care provider) must order the device and be included in all communication.	**0%** of the cost for non-Medicare covered telemonitoring services.
Please contact the plan for more details.	

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

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. When Urgent Care is received **outside the United States and its territories (worldwide coverage)** you will be responsible for $90 per incident. Network Platinum*Plus* will pay the remaining cost per incident up to the maximum $100,000 every year. Some facilities may bill Network Health directly, and this is the preferred method, using U.S. dollars. Other facilities may require you to pay the full cost of your care, and you will need to ask us to reimburse you for your costs. In this situation, you will be required to provide documents that may include a copy of the bill, proof of payment and English-language medical records (charges should be converted to U.S. dollars) for reimbursement up to the maximum of $100,000. Prescription drugs are not covered. *	Cost sharing for covered services within the United States and its territories applies toward the annual out-of-pocket maximum. **In-Network** **$15 to $40** copayment for each Medicare-covered urgently needed care visit within the United States and its territories. $40 copayment for each urgently needed visit at a free-standing urgent care facility. Urgently needed visits with a PCP will be performed at a $15 copayment, and urgently needed visits with a specialist will be performed at a $40 copayment. **$90** per incident for each non-Medicare covered urgently needed care visit outside the United States and its territories. **Out-of-Network** **$15 to $40** copayment for each Medicare-covered urgently needed care visit within the United States and its territories. $40 copayment for each urgently needed visit at a free-standing urgent care facility. Urgently needed visits with a PCP will be performed at a $15 copayment, and urgently needed visits with a specialist will be performed at a $40 copayment. **$90** per incident for each non-Medicare covered urgently needed care visit outside the United States and its territories.

* Cost sharing for covered services outside the United States and its territories (worldwide coverage) *does not* apply toward the annual out-of-pocket maximum.

Services that are covered for you	**What you must pay** when you get these services
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 of glaucoma, we will 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 cannot 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 not covered. **Note:** Cataract surgery may have outpatient hospital or ambulatory surgical center copayment. Please see outpatient hospital services. **Note:** Only the conventional intra-ocular lens is covered with either the blade or laser removal of a cataract. Insertion of lenses to correct vision are not covered. **Note:** Diagnostic testing copayments may apply. Please see Outpatient Diagnostic Testing for more information.	Cost sharing for Medicare covered services applies toward the annual out-of-pocket maximum. **In-Network** **$0** copayment for each Medicare-covered preventive glaucoma test. **$25** copayment for each Medicare-covered eye exam to diagnose and treat disease and conditions of the eye. **$0** copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery. **Out-of-Network** **$0** copayment for each Medicare-covered preventive glaucoma test. **$25** copayment for each Medicare-covered eye exam to diagnose and treat disease and conditions of the eye. **$0** copayment for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery.

Services that are covered for you	**What you must pay** when you get these services
Vision care – additional benefits We also cover routine vision services not covered by Original Medicare. We cover: • One non-Medicare covered routine eye exam per calendar year. * **Note:** Our provider network for routine vision services is different than our provider network for medical vision services. Non-Medicare covered vision services are administered by EyeMed. For more information and a link to the provider search, visit networkhealth.com/medicare/additional-benefits.	**In-Network** **$10** copayment for each non-Medicare covered routine eye exam. **Out-of-Network** Reimbursement up to a maximum of **$40** for each non-Medicare covered routine eye exam.
"Welcome to Medicare" preventive visit The 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 the preventive services you need (including certain screenings and shots) 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 would like to schedule your "Welcome to Medicare" preventive visit.	**In-Network** There is no coinsurance, copayment or deductible for the "Welcome to Medicare" preventive visit. **Out-of-Network** **$0** copayment for the "Welcome to Medicare" preventive visit.

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

Section 2.2 Extra "optional supplemental" benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. 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 Annual 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 Platinum*Plus*. If you terminate your Network Platinum*Plus* policy or lose eligibility, your supplemental dental benefit will also terminate. The monthly premium for the optional supplemental dental benefit in 2021 is $38. This is in addition to your monthly

Network Health Medicare Advantage Plan premium and 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. Dental services are administered by Delta Dental ("administrator"). Your supplemental dental coverage will be effective on the date your Network Platinum*Plus* 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. Please visit medicareadvantage.deltadentalwi.com to find an in-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 Annual 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.

Dental Optional Supplemental Benefit The dental optional supplemental benefit package is available for an additional monthly premium of $38. 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 choose to see an out-of-network dental provider, your share of the cost may be higher. If you receive services from a Dentist that has affirmatively opted not to participate with Medicare, Delta Dental will be unable to make any payments to either you or your Dentist and you will be responsible for all costs. Prior to receiving services from your Dentist, you should confirm whether or not your Dentist has affirmatively opted out of Medicare participation. * Please contact our member experience team (phone numbers located in the back of this booklet) with any questions.	Monthly Premium: $38 Annual Maximum: $1,000 Comprehensive Deductible: $100 **In-Network** **0%** of the cost for non-Medicare covered preventive and diagnostic dental services. Deductible does not apply. **50%** of the cost for non-Medicare covered basic and major dental services after the deductible. **Out-of-Network** **20%** of the cost for non-Medicare covered preventive and diagnostic dental services. Deductible does not apply. **50%** of the cost 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 2.3 Getting care using our plan's optional visitor/traveler benefit

When you are continuously absent from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a supplemental benefit called the visitor/traveler program which includes all U.S. territories and remaining 49 states outside Wisconsin. This program is available to all Network Platinum*Plus* members who are temporarily in the visitor/traveler area. Under our visitor/traveler program you may receive all plan covered services at in-network cost sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

When Emergency care is received **outside the United States and its territories (worldwide coverage)** you will be responsible for $90 per incident. Network Platinum*Plus* will pay the remaining cost per incident up to the maximum $100,000 every year. Some facilities may bill Network Health directly, and this is the preferred method, using U.S. dollars. Other facilities may require you to pay the full cost of your care, and you will need to ask us to reimburse you for your costs. In this situation, you will be required to provide documents that may include a copy of the bill, proof of payment and English-language medical records (charges should be converted to U.S. dollars) for reimbursement up to the maximum of $100,000. Prescription drugs are not covered.

It's important whenever you receive care from out-of-network or out-of-state providers that you confirm they accept Medicare assignment. If they do not accept Medicare assignment, they may charge 15 percent more than Medicare-covered charges. You will be responsible for the additional 15 percent cost sharing to the provider. The plan will pay the provider the Medicare approved amount for charges, minus your applicable cost sharing.

If you are in the visitor/traveler area, you can stay enrolled in our plan for up to six months. If you have not returned to the plan's service area within six months, you will be disenrolled from the plan.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not 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. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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 have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by our plan and 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. (See Chapter 3, Section 5 for more information on clinical research studies.)
Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare		✓
Private room in a hospital		✓ Covered only when medically necessary.
Private Duty Nurses	✓	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or television	✓	
Full-time nursing care in your home	✓	
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. It is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, including bathing or dressing.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	✓	
Fees charged for care by your immediate relatives or members of your household	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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	✓	
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.
Routine dental care, such as cleanings, fillings or dentures		✓ We cover one non-Medicare covered oral exam and one non-Medicare covered cleaning per year at Delta Dental Medicare Advantage in-network providers.
Residential AODA and mental health treatment	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, for example, if you have a condition caused by diabetes.
Home-delivered meals	✓	
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids		✓ Please refer to the "Hearing services" benefit in the Medical Benefits Chart for additional information.
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 (or contact lenses) are covered for people after cataract surgery. Routine eye examinations covered once per year. (Please refer to the "Vision care" benefit in the Medical Benefits Chart for additional information.)
Outpatient prescription drugs for treatment of sexual dysfunction, erectile dysfunction, impotence and anorgasmy or hyporgasmy	✓	
Prescriptions or refill of prescriptions because of theft, damage or loss of the prescription or drugs	✓	
Reversal of sterilization procedures and or non-prescription contraceptive supplies	✓	
Acupuncture		✓ Acupuncture for chronic low back pain. Please refer to the Medical Benefits Chart for additional information. Acupuncture as an alternative to nausea medications may be covered for members who are undergoing chemotherapy.
Naturopath services (uses natural or alternative treatments)	✓	
Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services 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	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-emergency transportation		✓ 24 one-way trips covered for all ESRD members to get to and from dialysis treatment. Please refer to the "Help with certain chronic conditions" benefit in the Medical Benefits Chart for additional information.
Home-based palliative care consultation and evaluation		✓ Members with end-stage cancer may qualify for this benefit. Please refer to the "Help with certain chronic conditions" benefit in the Medical Benefits Chart for additional information.

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CHAPTER 5

Asking us to pay our share of a bill you have received for covered medical services

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

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SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for an in-network provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When an in-network provider sends you a bill you think you should not pay

In-network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.
- Whenever you get a bill from an in-network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to an in-network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person's enrollment in the plan is retroactive. (Retroactive 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 will need to submit paperwork for us to handle the reimbursement.

Please call our member experience team for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for our member experience team are printed on the back cover of this booklet.)

4. If you receive emergency or urgent care outside the United States

When Emergency or Urgent care is received **outside the United States and its territories (worldwide coverage)** you will be responsible for $90 per incident. Network Platinum*Plus* will pay the remaining cost per incident, up to the maximum $100,000 every year. Some facilities may bill Network Health directly, and this is the preferred method, using U.S. dollars. Other facilities may require you to pay the full cost of your care, and you will need to ask us to reimburse you for your costs. In this situation, you will be required to provide documents that may include a copy of the bill, proof of payment and English-language medical records (charges should be converted to U.S. dollars) for reimbursement up to the maximum of $100,000. Prescription drugs are not covered.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are 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.
- Either download a copy of the form from our website (networkhealth.com) or call our member experience team and ask for the form. (Phone numbers for our member experience team are printed on the back cover of this booklet.)

Mail your request for payment together with any bills or receipts to us at this address:

For Medical Claims:
Network Health Medicare Advantage Plans
PO Box 568
1570 Midway Pl.
Menasha, WI 54952

For Routine Dental Claims
Delta Dental
PO Box 9215
Farmington Hills, MI 48333

For Routine Vision Claims
First American Administrators, Inc.
Attn: OON Claims
PO Box 8504
Mason, OH 45040-7111
Or online: https://www.processmyclaim.com/managed-vision-care/member-forms/out-of-network-claim/partner#/

For Prescription Claims
Express Scripts, Inc.
P.O. Box 14711
Lexington, KY 40512-4718

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

Contact our member experience team if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive 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 have already sent to us.

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

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will 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 will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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SECTION 1 Our plan must honor your rights as a member of the plan

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

To get information from us in a way that works for you, please call our member experience team (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, in large print or other alternate formats at no cost, if you need it. We are required to give you information about the 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, please call our member experience team (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with the discrimination complaints coordinator. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact plan our member experience team for additional information.

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

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

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

You have the right to choose a provider in the plan's network. Call our member experience team to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 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.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells 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.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are 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.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are 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 will 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 are not routine.

If you have questions or concerns about the privacy of your personal health information, please call our member experience team (phone numbers are printed on the back cover of this booklet).

Network Health Insurance Corporation ("NHIC") 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 are 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 are 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 will 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 will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, but we will 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 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 booklet).

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 cannot and will not 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 the plan, its network of providers, the organization, and your covered services

As a member of Network Platinum*Plus*, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call our member experience team (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our in-network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.

  - For more detailed information about our providers, you can call our member experience team (phone numbers are printed on the back cover of this booklet) or visit our website at networkhealth.com/find-a-doctor.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call our member experience team (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.6 We must support your right to participate with practitioners to make decisions about your care

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 when you go for medical care. 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 with practitioners. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to have a candid conversation of appropriate or medically necessary treatment options that are recommended for your condition, no matter what they cost or whether they are 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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to 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 are in this situation. This means that, *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.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a 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 contact our member experience team to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with The Wisconsin Department of Health Services, 1 West Wilson Street, Madison, WI 53703. The telephone number is 608-266-1865 (TTY accessible telephone number is 888-701-1251).

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision or make a complaint. Whatever you do – ask for a coverage decision, make an appeal or make a complaint – **we are required to treat you fairly**.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call our member experience team (phone numbers are printed on the back cover of this booklet).

Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call our member experience team** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call our member experience team** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should 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 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call our member experience team (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call our member experience team to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- **Tell your doctor and other health care providers you are enrolled in our plan.** Show your plan member ID card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions and following through on your care.**
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
    - 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 all 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 are responsible for these payments:
    - You must pay your plan premiums to continue being a member of our plan.
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) *or* coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
    - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call our member experience team (phone numbers are printed on the back cover of this booklet).
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up-to-date and know how to contact you.

  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

- **Call our member experience team for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for our member experience team are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

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

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical 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 keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. 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 are having. They can also answer your questions, give you more information and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **"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 the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her 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 will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

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 were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call our member experience team** (phone numbers are printed on the back cover of this booklet).
- You **can get free help from** your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care or Part B prescription drugs, your doctor can request 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. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under state law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call our member experience team (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at networkhealth.com.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal"
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon"
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call our member experience team (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay*). To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - 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**, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - Chapter 7, Section 6: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.

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

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision
(how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms
When a coverage decision involves your medical care, it is called an **"organization determination."** A "fast coverage decision" is called an **"expedited determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

How to request coverage for the medical care you want

- 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.

- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request for a medical item or service. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However,** a request **for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
    - **However,** for a request **for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received.)
    - 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 function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will 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 will decide whether your health requires that we give you a fast coverage decision.
    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
    - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
    - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
    - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."**

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

What to do

- **To start an appeal, you, your doctor or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call our member experience team (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at networkhealth.com. While we can

accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include: if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
    - You have the right to ask us for a copy of the information regarding your appeal.
    - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not received, we will give you our answer **within seven calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide 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 Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Step 1: The Independent Review Organization reviews your appeal.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
    - We will 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 of the information related to your appeal.

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, 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 Medicare Part B prescription drug.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an

answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within seven calendar days** of when it receives your appeal.

- However, 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 Medicare Part B prescription drug.

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

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

- **If the 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 receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute with **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests.**
- **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 should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third 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 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received 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 that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are 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 that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider 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 requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also 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 has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

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

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call our member experience team (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive 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 and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms
The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call our member experience team (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will 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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call our member experience team (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

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

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*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, Section 4, of this booklet.)

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.** (Your "discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) 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 may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling our member experience team (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

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 review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will 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. (See Chapter 4 of this booklet.)

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are 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 review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive 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 has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 that 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 of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received 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 is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the 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 will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed 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 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a** "**fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, 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 reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- 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

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more

information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

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

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage."**

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care and keep covering it for a longer period of time.
2. **You will be asked to sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: 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 will 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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it**. If you have questions or need help at any time, please call our member experience team (phone numbers are printed on the back cover of this booklet). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received 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, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- 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 for contacting the Quality Improvement Organization, and still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) 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 may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor and review information that our plan has given to them.

- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the "**Detailed Explanation of Non-Coverage."**

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will 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 services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- 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, then **you will 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.

- This first appeal you make is "Level 1" of the appeals process. 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 another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

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

- You must ask for this review **within 60 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 that 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 of the information related to your appeal.

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

What happens if the review organization says yes to your appeal?

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

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the 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 will 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 reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed 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 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get 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, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its' work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose 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 reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed 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 8 Taking your appeal to Level 3 and beyond

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

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have 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 cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal	**A judge (called 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** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will 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 service 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 this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your 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** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will 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 do not want to accept the decision, you might 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 on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

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

If your problem is about decisions related to benefits, coverage or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our member experience team has treated you? • Do you feel you are being encouraged to leave the 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 or other health professionals? Or by our member experience team or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting room or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say, "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling our member experience team is the first step.** If there is anything else you need to do, our member experience team will let you know. Call 920-720-1345 or 800-378-5234. TTY users call 800-947-3529, Monday - Friday from 8 a.m. to 8 p.m. **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will 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. If you request a fast coverage determination or appeal and we deny your request, we will call you and send you a letter within 72 hours notifying you that your request will automatically follow the standard grievance and appeals process.
- **Whether you call or write, you should contact our member experience team right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint".** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

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

- **If possible, we will 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. If your health condition requires us to answer quickly, we will do that.
- **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 will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

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

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - 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.

- To find the name, address and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or, you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Network Platinum*Plus* directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Network Platinum*Plus* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

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

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can 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:
    - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Original Medicare *with* a separate Medicare prescription drug plan.
    - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
    - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
    - Disenroll from our plan and obtain 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.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
    - Usually, when you have moved.
    - If you have Wisconsin Medicaid.
    - If we violate our contract with you.
    - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you

can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:

  - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan;
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call our member experience team** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2021*** handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact our member experience team if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- – *or* – You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from Network Platinum*Plus* when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled Network Platinum*Plus* when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact our member experience team if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Network Platinum*Plus* when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Network Platinum*Plus*, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

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

SECTION 5 Network Platinum*Plus* must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Network Platinum*Plus* must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.

- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call our member experience team to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for our member experience team are printed on the back cover of this booklet.)
    - Go to Chapter 4, Section 2.3 for information on getting care when you are away from the service area through our plan's visitor/traveler benefit.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot 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 cannot 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 cannot 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 do not pay the plan premiums **and** your account balance is $250.00 or more for three consecutive months.
    - We must notify you in writing that you have *three months* to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can **call our member experience team** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Network Platinum*Plus* is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

Section 5.3 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 about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

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SECTION 4 Third Party Liabilities 163

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this 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, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, 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, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TDD 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call our member experience team (phone numbers are printed on the back cover of this booklet). 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 Platinum*Plus*, 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 Platinum*Plus*, 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 Platinum*Plus*, 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 Platinum*Plus*, 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 Platinum*Plus,* 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 of important words

Chapter 10. Definitions of important words

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 does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20 percent).

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

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

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit or a prescription. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) 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 received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use in this EOC to mean all of 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.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as 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.

Customer Service – See Member Experience Team.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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, 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 is quickly getting worse.

Emergency Care – Covered services that are; 1) rendered 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.

Grievance – A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide 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). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have 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 are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven-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.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from in-network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.2 for information about your in-network maximum out-of-pocket amount.

In-Network Pharmacy – An in-network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "in-network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our in-network pharmacies.

In-Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**in-network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays in-network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. In-network providers may also be referred to as "plan providers."

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain 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 from January 1 until March 31, and is also available for a 3-month period after an individual 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 HMO, PPO, a Private Fee-for-Service (PFFS) plan or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

"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 (previously called Customer Service) – A department within our plan responsible for answering your questions about your membership, benefits, grievances and appeals. See Chapter 2 for information about how to contact our member experience team.

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.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision 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 booklet. Chapter 7 explains how to ask us for a coverage decision.

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-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

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 are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from 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.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other in-network provider gets "prior authorization" from us.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are 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.

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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. 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. The plan may disenroll you if you permanently move out of the 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 skilled nursing facility 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 reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another Part D or Part B covered drug to treat your medical condition before we will cover the Part D or Part B drug your physician may have initially prescribed.

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 are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by in-network providers or by out-of-network providers when in-network providers are temporarily unavailable or inaccessible.

Network Platinum*Plus* Member Experience Team

Method	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	800-947-3529 This number requires special telephone equipment and is only for people who have difficulties with 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

The Board on Aging and Long Term Care (Wisconsin SHIP)

The Board on Aging and Long Term Care (Wisconsin SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-815-0015 Ombudsman Program/Volunteer Program 1-800-242-1060 Medigap Helpline
WRITE	The Board on Aging and Long Term Care 1402 Pankratz Street, Suite 111 Madison, WI 53704-4001
WEBSITE	longtermcare.wi.gov

network health

GOING ABOVE AND BEYOND

1570 Midway Pl.
Menasha, WI 54952
800-378-5234
TTY 800-947-3529
Monday–Friday, 8 a.m. to 8 p.m.
networkhealth.com

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