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007

2026 EVIDENCE OF COVERAGE

NETWORK HEALTH MEDICARE ADVANTAGE PLANS

Network Health Cares PPO



January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of Network Health Cares (PPO D-SNP)

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

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

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

For questions about this document or to order a printed copy, please contact our member experience team at 855-653-4363 (TTY users call 711). Hours are, Monday – Friday from 8 a.m. to 8 p.m. From October 1, 2025 through March 31, 2026, we are available every day from 8 a.m. to 8 p.m. This call is free.

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

Network Health Cares is a PPO D-SNP plan with a Medicare contract and a contract with the Wisconsin Medicaid Program. Enrollment in Network Health Medicare Advantage Plans depends on contract renewal.

Benefits, premiums and/or copayments/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of Network Health Cares

Section 1.1 You're enrolled in Network Health Cares, which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is 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 (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that aren't covered by Medicare.

You've chosen to get your Medicare health care and your drug coverage through our plan, Network Health Cares. Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

Network Health Cares is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. Network Health Cares is designed for people who have Medicare and are entitled to help from Medicaid.

Because you get help from Medicaid with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Medicaid may also provide other benefits by covering health care services that aren't usually covered under Medicare. You may also get Extra Help from Medicare to pay for the costs of your Medicare drugs. Network Health Cares will help you manage all these benefits, so you get the health services and payment help that you're entitled to.

Network Health Cares is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a contract with the Wisconsin Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare coverage, including your drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

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

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

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

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Medicaid.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within three (3) month(s), then you're still eligible for membership. Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility.

Section 2.2 Medicaid

Medicaid is a joint federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people 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 and 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 and SLMB+):** Helps pay Part B premiums.
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

Section 2.3 Plan service area for Network Health Cares

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

Our service area includes these counties in Wisconsin: Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kenosha, Kewaunee, Manitowoc, Marinette, Marquette, Milwaukee, Oconto, Outagamie, Ozaukee, Portage, Racine, Shawano, Sheboygan, Washington, Waukesha, Waupaca, Waushara and Winnebago.

If you plan to move to a new state, you should also contact your state’s Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

If you move out of our plan’s service area, you can’t stay a member of this plan. Call our member experience team at 855-653-4363 (TTY users call 711) to see if we have a plan in your new area. When you move, you’ll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

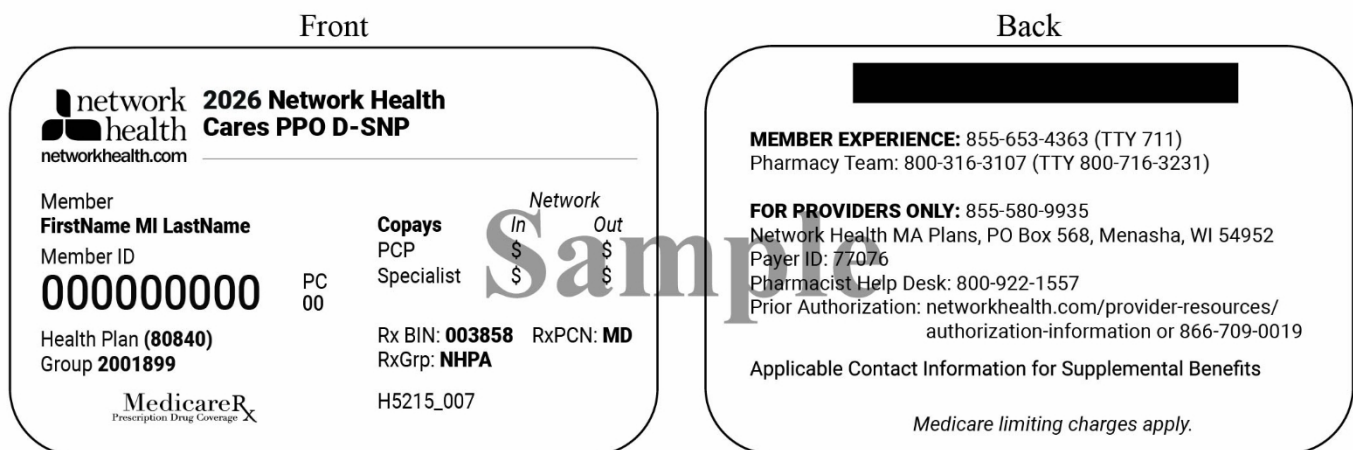
Section 2.4 U.S. citizen or lawful presence

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

SECTION 3 Important membership materials

Section 3.1 Our plan member ID card

Use your member ID card whenever you get services covered by our plan and for prescription drugs you get at in-network pharmacies. You should also show the provider your Medicaid card. Sample member ID card:



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

If our plan member ID card is damaged, lost, or stolen, call our member experience team at 855-653-4363 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* networkhealth.com/find-a-doctor lists our current in-network providers and durable medical equipment suppliers.

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.

It is important to know which providers are part of our network because, with limited exceptions, while you're a member of our plan you may be required to use in-network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services and cases in which Network Health Cares authorizes use of out-of-network providers. Go to Chapter 3 (Using our plan's coverage for your medical services) for more specific information about emergency, out-of-network and out-of-area coverage. The provider you choose to see must accept Wisconsin Medicaid. Check with your provider before receiving services to confirm they will bill Wisconsin Medicaid. You will be responsible for the Medicaid portion of your medical bill if you choose a provider who doesn't accept Wisconsin Medicaid.

The most recent list of providers and suppliers is on our website at networkhealth.com/find-a-doctor.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from our member experience team at 800-378-5234 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within three business days.

Section 3.3 Pharmacy Directory

The *Pharmacy Directory* networkhealth.com/find-a-pharmacy lists our in-network pharmacies. **In-network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the in-network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from our member experience team at 855-653-4363 (TTY users call 711). You can also find this information on our website at networkhealth.com/find-a-pharmacy.

Section 3.4 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit in Network Health Cares. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The Drug List must meet Medicare’s requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Network Health Cares Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We’ll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit networkhealth.com/look-up-medications or call our member experience team at 855-653-4363 (TTY users call 711).

SECTION 4 Summary of Important Costs for 2026

	Your Costs in 2026
<p>Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.</p>	\$0
<p>Deductible</p>	<p>In 2025 the amount was \$0 or \$257+ +These amounts may change for 2026 If you are eligible for Medicare cost-sharing help under Medicare, you pay \$0</p>
<p>Maximum out-of-pocket amount This is the <u>most</u> you’ll pay out-of-pocket for covered Part A and B services. (Go to Chapter 4 Section 1 for details.)</p>	<p>From in-network providers: \$9,250</p> <p>From in-network and out-of-network providers combined: \$13,900</p> <p>If you are eligible for Medicare cost-sharing help under Medicaid, you are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.</p>

	Your Costs in 2026
<p>Primary care office visits</p>	<p style="text-align: center;">In-network 0% to 20% of the allowed amount per visit</p> <p style="text-align: center;">Out-of-Network 0% to 20% of the allowed amount per visit If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</p>
<p>Specialist office visits</p>	<p style="text-align: center;">In-network 0% to 20% of the allowed amount per visit</p> <p style="text-align: center;">Out-of-Network 0% to 20% of the allowed amount per visit If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</p>
<p>Inpatient hospital stays</p>	<p>In 2025, the amounts for each benefit period were:</p> <p style="text-align: center;">Days 1-60: \$1,676 deductible+</p> <p style="text-align: center;">Days 61-90: \$419 per day+</p> <p style="text-align: center;">Days 91-150: \$838 per lifetime reserve day+</p> <p style="text-align: center;">+These amounts may change for 2026.</p> <p>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.</p>
<p>Part D drug coverage deductible (Go to Chapter 6 Section 4 for details.)</p>	<p style="text-align: center;">\$615</p> <p style="text-align: center;">except for covered insulin products and most adult Part D vaccines.</p>
<p>Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)</p>	<p style="text-align: center;">Copayment/Coinsurance during the Initial Coverage Stage:</p> <p style="text-align: center;">Drug Tier 1: 25% You pay the lesser of \$35 or 25% per month supply of each covered insulin product on this tier.</p> <p style="text-align: center;">Catastrophic Coverage Stage: During this payment stage, you pay nothing for your covered Part D drugs.</p>

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for Network Health Cares.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most Network Health Cares members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.

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

Medicare Part B Premium Giveback

The Medicare Part B Premium Giveback is when Network Health Cares pays \$2.90 toward your Medicare Part B premium.

If your Medicare Part B premium is automatically deducted from your monthly Social Security check, Network Health Cares will pay up to \$2.90 of your Medicare Part B premium. This means your monthly Social Security check will be \$2.90 more each month.

If you pay your Medicare Part B premium via a monthly premium statement, your statement will show a \$2.90 credit, meaning you will pay \$2.90 less per month.

You're eligible to receive the Medicare Part B premium giveback if:

- You're enrolled in Medicare Parts A and B; and
- You pay your own Medicare Part B premium; and
- You live in a service area that offers a Part B giveback.

When you switch to Network Health Cares, it could take up to 90 days for this new benefit to begin being processed. As a result, you may not see the increase in your Social Security check or credit on your premium statement for a few months after the effective date of this plan. Any missed giveback will be credited toward your premium after processing is complete.

Please note that if you disenroll from this plan, your Medicare Part B premium benefit will end on the date of disenrollment. Any premium giveback you receive after you disenroll will eventually be deducted from your Social Security check.

Section 4.3 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

When you first enroll in Network Health Cares, we let you know the amount of the penalty.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.

Note: Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.

Note: Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you didn't have creditable drug coverage, if the break in coverage was 63 days or more. The penalty is one percent for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14 percent.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is \$38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14 percent times \$38.99, which equals \$5.4586. This rounds to \$5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.

- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes to income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from two years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit [Medicare.gov/health-drug-plans/part-d/basics/costs](https://www.Medicare.gov/health-drug-plans/part-d/basics/costs).

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year we'll tell you in September and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed, or need to start paying a late enrollment penalty if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year:

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep your plan membership record up-to-date

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

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up-to-date.

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

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

If any of this information changes, let us know by calling our member experience team at 855-653-4363 (TTY users call 711).

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

You should also call Wisconsin Medicaid (see Chapter 2, Section 6 for contact information) to report any of the above changes.

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call our member experience team at 855-653-4363 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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) are 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 or domestic partner) are 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 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 and/or employer group health plans have paid.

CHAPTER 2: Phone numbers and resources

SECTION 1 Network Health Cares contacts

For help with claims, billing, or member ID card questions, call or write to the Network Health Cares Member Experience Team. We'll be happy to help you.

Member Experience Team – Contact Information

Call	855-653-4363 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m. Our member experience team also has free language interpreter services available for non-English speakers.
TTY	711 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 ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions and Appeals for Medical Care or Appeals for Part D drugs – Contact Information

Call	855-653-4363 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	Coverage Decisions for Medical Care: 920-720-1916 Appeals for Medical Care or Part D prescription drugs: 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

Coverage Decisions for Part D Drugs – Contact Information

Call	800-316-3107 Calls to this number are free. 24 hours a day, seven days a week.
TTY	800-716-3231 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 24 hours a day, seven days a week.
Fax	877-251-5896
Write	Express Scripts Attention: Medicare Reviews PO Box 66571 St. Louis, MO 63166-6571
Website	networkhealth.com

How to make a complaint about your medical care

You can make a complaint about us or one of our in-network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information

Call	855-653-4363 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	920-720-1832
Write	Network Health Medicare Advantage Plans Attn: Appeals and Grievances PO Box 120 1570 Midway Pl. Menasha, WI 54952
Medicare website	To submit a complaint about Network Health Cares directly to Medicare go to Medicare.gov/my/medicare-complaint .

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

Network Health Cares (PPO D-SNP) can’t reimburse you for Wisconsin Medicaid covered benefits. It is your responsibility to work directly with Wisconsin Medicaid to seek reimbursement. For assistance in doing so, please contact our member experience team at 855-653-4363 (TTY users call 711).

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests for Part C Claims – Contact Information

Call	855-653-4363 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
TTY	711 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
Fax	920-720-1905
Write	Network Health Medicare Advantage Plans PO Box 120 1570 Midway Pl. Menasha, WI 54952
Website	networkhealth.com

Payment Requests for Part D Claims – Contact Information

Call	800-316-3107 Calls to this number are free. 24 hours a day, seven days a week
TTY	800-716-3231 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 24 hours a day, seven days a week
Fax	608-741-5483
Write	Express Scripts Attn: Medicare Part D PO Box 52023 Phoenix, AZ 85072
Website	networkhealth.com

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information

Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, seven days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Chat live	Chat live at Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044

Website

[Medicare.gov](https://www.medicare.gov)

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.
- Find Medicare-participating doctors or other health care providers and suppliers.
- Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.
- Look up helpful websites and phone numbers.

You can also visit [Medicare.gov](https://www.medicare.gov) to tell Medicare about any complaints you have about Network Health Cares.

To submit a complaint to Medicare, go to [Medicare.gov/my/medicare-complaint](https://www.medicare.gov/my/medicare-complaint). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

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

Wisconsin SHIP - Contact Information

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

SECTION 4 Quality Improvement Organization (QIO)

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

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

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

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

Commence Health BFCC-QIO Program (Wisconsin's Quality Improvement Organization) – Contact Information

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

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. Social Security is also responsible for determining who has to pay an extra amount for Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Social Security– Contact Information

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

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

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 and SLMB+):** Helps pay Part B premiums
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

If you have questions about the help you get from Medicaid, contact Wisconsin Medicaid.

Wisconsin Medicaid helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

Wisconsin Medicaid – Contact Information

Call	1-800-362-3002 Available Monday – Friday from 8 a.m. to 6 p.m.
TTY	711

Wisconsin Medicaid – Contact Information

Write	Department of Health Services 1 West Wilson St. Madison, WI 5370 memberservices@wisconsin.gov
Website	dhs.wisconsin.gov/medicaid

The Long Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Long Term Care Ombudsman – Contact Information

Call	1-800-815-0015
Write	Board on Aging and Long Term Care 1402 Pankratz St., Suite 111 Madison, WI 53704-4001
Website	dhs.wisconsin.gov/aging/ltcombud.htm

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website ([medicare.gov/basics/costs/help/drug-costs](https://www.medicare.gov/basics/costs/help/drug-costs)) has information on how to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- The Social Security Office at 1-800-772-1213, between 8 a.m. and 7 p.m., Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at 1-800-362-3002.

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- To provide us evidence so you can be set up with the correct Low-Income Subsidy Level, please call our member experience team by phone at 855-653-4363 or fax us at 920-720-1905, Monday – Friday from 8 a.m. to 8 p.m.

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call our member experience team at 855-653-4363 (TTY users call 711) if you have questions.

Most of our members qualify for and are already getting Extra Help from Medicare to pay for their prescription drug plan costs.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, to help you manage your costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026. Extra Help from Medicare, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan.** To learn more about this payment option, call Express Scripts customer service at 866-845-1803 (TTY users call 800-716-3231) or visit [Medicare.gov](https://www.Medicare.gov).

Medicare Prescription Payment Plan – Contact Information

Call	1-866-845-1803 Calls to this number are free. 24 hours a day, seven days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	1-800-716-3231 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. 24 hours a day, seven days a week.
Fax	Not applicable
Write	Express Scripts Medicare Prescription Payment Plan PO Box 2 Saint Louis, MO 63166 This address is only to be used for general inquiries. Paper election forms and payments should not be mailed to this address.
Website	express-scripts.com/mppp

SECTION 8 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information

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

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or our member experience team at 855-653-4363 (TTY users call 711) if you have any questions. You can ask about your (or your spouse or domestic partner’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 document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2018.

If you have other drug coverage through your (or your spouse or domestic partner’s) employer or retiree group, contact **that group’s benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

SECTION 10 Get help from your local Aging and Disability Resource Center

- Brown County: 920-448-4300
- Calumet County: 833-620-2730
- Dodge County: 800-924-6407
- Door County: 855-828-2372

- Fond du Lac County: 888-435-7335
- Green Lake County: 833-694-0192
- Kenosha County: 800-472-8008
- Kewaunee County: 877-416-7083
- Manitowoc County: 877-416-7083
- Marinette County: 888-442-3267
- Marquette County: 855-440-2372
- Milwaukee County: 414-289-6874
- Oconto County: 855-492-2372
- Outagamie County: 866-739-2372
- Ozaukee County: 866-537-4261
- Portage County: 866-920-2525
- Racine County: 866-219-1043
- Shawano County: 855-492-2372
- Sheboygan County: 800-596-1919
- Washington County: 877-306-3030
- Waukesha County: 866-677-2372
- Waupaca County: 888-454-8112
- Waushara County: 877-883-5378
- Winnebago County: 877-886-2372

CHAPTER 3: Using our plan for your medical services

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

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

Section 1.1 In-network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term *providers* also includes hospitals and other health care facilities.
- **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 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 covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare health plan, Network Health Cares must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare.

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

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

SECTION 2 Use providers in our plan's network to get medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your 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 Health Cares (PPO D-SNP) 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 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 to choose a PCP?

Selecting a primary care provider (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 Health Cares will communicate with your PCP to help coordinate your care.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers and you'd need to choose a new PCP.

If you would like assistance with finding a new PCP, our member experience team can assist you. Also, 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. For 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 Health Cares (PPO D-SNP) doesn't 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.

If you need certain types of services, your PCP or specialist may need to get prior authorization (prior approval) from Network Health Cares (PPO D-SNP) 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.

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

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization would be required to obtain out-of-network services at the in-network cost sharing.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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. 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, that provider must participate in Medicare. Check with your provider before receiving services to confirm they have not opted out of Medicare. Network Health Cares (PPO D-SNP) cannot pay a provider who has decided to not participate in Medicare.

- You will be responsible for the Medicaid portion of your medical bill if you choose an out-of-network provider who doesn't accept Wisconsin Medicaid (your Forward Health card).
- You do not 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 call Utilization Management at 920-720-1602 or 866-709-0019 to tell us you're going to use an out-of-network provider and to confirm the services you're getting are medically necessary. This is important because:
 - 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 9 (*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 our 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 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you're using an out-of-network provider for emergency care, urgently needed care 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 services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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 your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain or a medical condition that's quickly getting worse.

If you have a medical emergency:

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

Covered services in a medical emergency?

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

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

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we'll try to arrange for in-network providers to take over your care as soon as your medical condition and the circumstances allow.

Note: Wisconsin Medicaid may not have coverage outside of the State of Wisconsin.

Note: It is 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. Our plan will pay the provider the Medicare-approved amount for charges, minus your applicable cost sharing.

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

When receiving emergency services **outside the United States and its territories (worldwide coverage)** you will be responsible for \$125 per incident. Please note, once you transfer out of the emergency department, Network Health will no longer pay for services, including if you remain inpatient in a hospital. Network Health Cares will pay the remaining cost per incident up to the maximum \$100,000 every year. For example, if you require urgent care services that span two calendar years (December to January) the maximum covered amount is \$100,000. 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.

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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these two ways:

- You go to an in-network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area or it's unreasonable given your time, place, and circumstances to get this service from in-network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

You should always try to obtain urgently needed services from in-network providers. However, if providers are temporarily unavailable or inaccessible and it isn't reasonable to wait to obtain care from your in-network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

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. You may also call our member experience team (phone numbers are located on the back cover of this document) if you need assistance locating an urgent care provider.

When you're 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.

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

Note: It is 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. Our plan will pay the provider the Medicare-approved amount for charges, minus your applicable cost sharing.

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

When receiving urgently needed services **outside the United States and its territories (worldwide coverage)** you will be responsible for \$125 per incident. Please note, once you transfer out of the emergency department, Network Health will no longer pay for services, including if you remain inpatient in a hospital. Network Health Cares will pay the remaining cost per incident up to the maximum \$100,000 every year. For example, if you require urgent care services that span two calendar years (December to January) the maximum covered amount is \$100,000. 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.

Note: Wisconsin Medicaid may not have coverage outside of the State of Wisconsin.

Section 3.3 Get care during a disaster

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

Visit [networkhealth.com/medicare/medicare-pdfs/medicare-disaster-policy_f_508.pdf](https://www.networkhealth.com/medicare/medicare-pdfs/medicare-disaster-policy_f_508.pdf) for information on how to get needed care during a disaster.

If you can't use an in-network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use an in-network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

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

If you paid more than our plan cost sharing for covered services or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.2 If services aren't covered by our plan

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

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

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study?

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

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

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

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

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

Section 5.2 Who pays for services in a clinical research study?

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test and you would pay the \$20 copayment required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you \$10. That makes your net payment for the test \$10, the same amount you'd pay under our plan's benefits.

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Network Health Cares, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call our member experience team at 855-653-4363 (TTY users call 711) for more information.

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

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

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

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

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

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

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

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

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

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

Types of out-of-pocket costs you may pay for covered services include:

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about our plan deductible.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the allowed amount of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Section 1.2 Our plan deductible

Your deductible is \$0 or \$257. These amounts may change for 2026. Until you've paid the deductible amount, you must pay the full cost of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services, and you'll pay your share (your coinsurance amount) for the rest of the calendar year.

The yearly deductible also applies to your Medicare Part B Drugs. Depending on your level of Medicaid eligibility you may not have any cost sharing responsibility for Original Medicare services.

The deductible doesn't apply to some services. This means that we pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible doesn't apply to the following services:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)

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

- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings
- HIV screening
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including flu shots, hepatitis B shots, pneumococcal shots
- Welcome to Medicare preventive visit (one-time)
- Yearly “wellness” visit
- Emergency care received in the United States and its territories
- Urgently needed care received inside the United States and its territories
- Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)

The deductible doesn't apply to any of the services listed above when received from an in-network provider. The deductible will not apply to any additional preventive services approved by Medicare during the contract year when received from an in-network provider. Additionally, the deductible will not apply to emergency care or urgently needed care received in the United States from an out-of-network provider.

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the in-network MOOP amount is \$9,250. The in- and out-of-network combined MOOP amount is \$13,900.**

The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$9,250 for in-network or \$13,900 for combined in- and out-of-network services, you won't have to pay 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 the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers aren't allowed to balance bill you

As a member of Network Health Cares, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15), you pay only that amount for any covered services from an in-network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get 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. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
 - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services outside the service area.)
- If you think a provider has balance billed you, call our member experience team at 855-653-4363 (TTY users call 711).

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

The Medical Benefits Chart on the next pages lists the services Network Health Cares covers and what you pay out-of-pocket for each service (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.

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

- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other in-network provider gets approval from us in advance (sometimes called prior authorization).
 - Covered services that need approval in advance are marked in the Medical Benefits Chart in italics. These services not listed in the Medical Benefits Chart also require prior authorization:
 - 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, spine surgery and all procedures that could be considered cosmetic
 - Certain durable medical equipment such as wheelchairs, orthotics, prosthetics and electrical stimulators
 - Outpatient radiation oncology services
 - Outpatient interventional pain injections and procedures
 - Outpatient physical and occupational therapy services (including when provided during home health care)
 - Outpatient gastroenterology (EGDs, capsule endoscopy and non-preventive colonoscopies)
 - Non-emergent ambulatory injectable chemotherapy drugs
 - Certain medications under your medical benefit
 - Genetic testing
 - Diagnosis and treatment of peripheral vascular disease
 - Continuous Glucose Monitoring (CGM) devices. CGM supplies purchased at an in-network pharmacy also require prior authorization.
 - You do not 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.
- Services requiring prior authorization may change occasionally. Our most up-to-date list of services requiring prior authorization can be accessed through your member portal.

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services. Medicaid also covers services Medicare doesn't cover. Please contact Wisconsin Medicaid Member Services at 800-362-3002, Monday – Friday, 8 a.m. to 6 p.m. for additional information.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at [Medicare.gov](https://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE 1-800-633-4227 (TTY users call 1-877-486-2048).
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.


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

- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.
 - Network Health Cares (PPO D-SNP) will receive and pay your claims first and Wisconsin Medicaid will pay for any remaining costs, minus any Wisconsin Medicaid copayments. The benefits chart below is reflective of what Network Health Cares (PPO D-SNP) will pay. The benefits charts shows what Network Health Cares (PPO D-SNP) pays first before your claim is sent to Wisconsin Medicaid. To find out what your Wisconsin Medicaid cost sharing and copayments will be, please see your Network Health Cares (PPO D-SNP) Summary of Benefits or contact Wisconsin Medicaid.
- If you're within our plan's three-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, you're responsible for the Medicare coinsurance and deductibles unless you regain your Wisconsin Medicaid with no gap in coverage. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.
- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
 - Cancer
 - Acupuncture: Up to 12 visits per year are covered for members who are undergoing chemotherapy and experiencing severe nausea.
 - End-stage renal disease
 - Transportation: Up to 24 one-way trips per year for members diagnosed with End-Stage Renal Disease to get to and from dialysis for treatment.
- For more detail, go to the *Help with Certain Chronic Conditions* row in the Medical Benefits Chart below.
 - Call our member experience team at 855-653-4363 (TTY users call 711) for more information.



This apple shows the preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for members eligible for this preventive screening.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for members eligible for this preventive benefit.</p>
<p>Acupuncture for chronic low back pain</p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient isn't improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered acupuncture treatment.</p>

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

Commission on Acupuncture and Oriental Medicine (ACAOM); and,

- a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.

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

Ambulance services

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

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

Cost sharing applies to each one-way transport.

In- and Out-of-Network

0% to 20% of the allowed amount for each Medicare-covered ground or air ambulance trip.

 **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.

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

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

In-Network

There is no coinsurance, copayment or deductible for the Annual wellness visit.

Out-of-Network

0% to 20% of the allowed amount for members eligible for this preventive benefit.

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

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.

Note: Your Annual physical exam differs from your annual wellness visit. For more information about what type of exam you're receiving please discuss this with your personal doctor.

 **Bone mass measurement**

For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

In-Network

There is no coinsurance, copayment or deductible for Medicare-covered bone mass measurement.

Out-of-Network

0% to 20% of the allowed amount for members eligible for Medicare-covered bone mass measurement.

 **Breast cancer screening (mammograms)**

Covered services include:

- One baseline mammogram between the ages of 35 and 39
- One screening mammogram every 12 months for women aged 40 and older
- Clinical breast exams once every 24 months
- 2D and 3D mammograms

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 and deductibles for covered services apply toward the annual out-of-pocket maximum.

In-Network


There is no coinsurance, copayment or deductible for covered screening mammograms.

Out-of-Network

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

<p>cost sharing as described under Outpatient Diagnostic Tests and Therapeutic Services and Supplies in this chart. Therefore, the screening mammography annual benefit isn't available for members who have signs or symptoms of breast cancer.</p>	<p>0% to 20% of the allowed amount for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>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.</p> <p>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. For more information on Peripheral Arterial Disease (PAD) rehabilitation see Supervised exercise therapy benefit in this chart.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered cardiac rehabilitation or intensive cardiac rehabilitation service.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease screening tests</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for cardiovascular disease testing</p>

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

	<p>that is covered once every five years.</p> <p>Out-of-Network 0% to 20% of the allowed amount for cardiovascular disease testing that is covered once every five years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months. 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network There is no coinsurance, copayment or deductible for Medicare-covered preventive Pap and pelvic exams.</p> <p>Out-of-Network 0% to 20% of the allowed amount for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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. <p>We do not cover maintenance chiropractic care, exams or x-rays. You're responsible for 100% of the cost of maintenance chiropractic care.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>You pay 100% of the cost for maintenance care.</p> <p>In- and Out-of-Network 0% to 20% of the allowed amount for each Medicare-covered chiropractic visit</p>
<p>Chronic pain management and treatment services</p> <p>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than three months). Services may include pain assessment, medication management, and care coordination and planning.</p>	<p>Cost sharing for this service will vary depending on the individual services provided under the course of treatment.</p> <p>In- and Out-of-Network</p>

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

0% to 20% of the allowed amount for each Medicare-covered chronic pain management and/or treatment visit.



Colorectal cancer screening

The following screening tests are covered:

- Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at a high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.
- Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.
- Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography.
- Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.
- Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years.
- Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every three years.
- Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.
- Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

In-Network

There is no coinsurance, copayment or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Out-of-Network

0% to 20% of the allowed amount for a Medicare-covered colorectal cancer screening exam.

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.

Dental services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.

Predeterminations are recommended for all dental services.

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

**In- and Out-of-Network
 0% to 20% of the allowed amount** for each Medicare-covered dental service.

Dental services – extra benefits *

We cover preventive and comprehensive dental services not covered by Original Medicare. We cover:

Non-Medicare covered preventive and basic dental services

- Routine dental exams and cleanings twice a year
- Fluoride treatments once a year
- Bitewing X-rays once a year
- Full mouth X-ray, once per five years
- Emergency palliative treatment
- Minor restorative services, simple extractions-nonsurgical extractions, fillings and crown repair

Non-Medicare covered major dental services

- Major Restorative services
- Endodontics
- Periodontics
- Extractions
- Prosthodontics

Annual maximum coverage of \$3,000 combined for preventive and comprehensive dental services

In-Network

0% of the allowed amount for preventative and basic dental services.

0% of the allowed amount for major dental services.

Out-of-Network

0% of the allowed amount for preventive and basic dental services.

50% of the allowed amount for major dental services.

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



- Oral Surgery
- Relines and repairs to bridges and dentures


Up to \$3,000 annual maximum benefit applies to both in- and out-of-network services received for non-Medicare covered dental services. If you receive services from a dentist that doesn't participate in the dental network, you will be responsible for the difference between our payment and the amount charged by the non-participating dentist. Please contact our member experience team (phone numbers located in the back of this document) with any questions.

Note: Our provider network for non-Medicare covered dental services is different than our provider network for medical dental services. For a link to the provider search and the dental certificate, visit networkhealth.com/medicare/extra-benefits-snp. You can also request a hard copy of the dental certificate by calling our member experience team.

* Your cost sharing and deductibles for non Medicare-covered services doesn't apply toward the annual out-of-pocket maximum.

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

Covered Service	What you pay
<p> Depression screening</p> <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network There is no coinsurance, copayment or deductible for an annual depression screening visit.</p> <p>Out-of-Network 0% to 20% of the allowed amount for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network There is no coinsurance, copayment or deductible for the Medicare-covered diabetes screening tests.</p> <p>Out-of-Network 0% to 20% of the allowed amount for the Medicare-covered diabetes screening tests.</p>

Covered Service	What you pay
<p> Diabetes self-management training, diabetic services, and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Preferred blood glucose monitors, preferred blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (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. <p>Note: Preferred continuous glucose monitoring devices require prior authorization confirming member uses insulin for management of their diabetes. Continuous glucose monitoring supplies, when purchased at an in-network pharmacy, also require prior authorization.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for beneficiaries eligible for diabetes self-management training.</p> <p>0% to 20% of the allowed amount for preferred test strips and each diabetic supply item up to a 90-day supply.</p> <p>0% to 20% of the allowed amount for preferred continuous glucose monitoring devices and supplies with an approved prior authorization. All other brands are excluded.</p> <p>0% to 20% of the allowed amount for each pair of Medicare-covered diabetic therapeutic shoes or inserts.</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of durable medical equipment, go to Chapter 12 and Chapter 3)</p> <p>Covered items include, but aren't limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. Most DME requires a prior authorization. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at networkhealth.com.</p> <p>Note: As a newly enrolled member under a current durable medical equipment rental agreement, you will need to start your 13-month rental over unless you can provide proof of rental documentation from your durable medical equipment supplier. For more information, please contact our member experience team.</p> <p>To acquire ownership for certain types of durable medical equipment, our 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</p>	<p>In- and Out-of-Network</p> <p><i>In-network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount for each Medicare-covered durable medical service or item.</p> <p>Your cost sharing for Medicare oxygen equipment coverage is 0% to 20% of the Medicare approved amount, every month for the first 36 months.</p> <p>After 36 months of continuous oxygen equipment coverage, your cost sharing will be 0% for maintenance and servicing for the remainder of the reasonable useful</p>

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

Covered Service	What you pay
<p>a member of Network Health Cares, 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. Our 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 doesn't transfer to you.</p> <p>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.</p> <p>Note: DME purchased at a retail store isn't a covered benefit, this includes both online and brick and mortar retail stores.</p> <p>Note: Traditional insulin pumps (insulin pumps that use tubing) such as Medtronic and Tandem are covered under Medicare Part B. Tubeless insulin pumps, such as Omnipod, are covered under your Part D prescription drug benefit.</p> <p>If you have questions about your medical costs or how to receive durable medical equipment when you travel, please call our member experience team.</p>	<p>lifetime (five years). If your equipment is replaced, a new 36-month capped rental period will begin and your cost sharing will be 0% to 20% of the Medicare approved amount, every month.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.</p> <p>Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.</p> <p>Note: Medicare Part B generally doesn't pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in the emergency room. Self-administered drugs may be covered</p>	<p>Cost sharing for covered services within the United States and its territories applies toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount (up to \$100) for each Medicare-covered emergency room visit within the United States and its territories.</p> <p>\$125 per incident for each non-Medicare covered emergency room visit outside the United States and its territories.</p>

Covered Service	What you pay
<p>under your Part D benefit; however there is no Part D coverage for over-the-counter medications.</p> <p>Note: It is 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. Our plan will pay the provider the Medicare-approved amount for charges, minus your applicable cost sharing.</p> <p>Note: If you're in the visitor/traveler area, you can stay enrolled in our plan for up to six months. If you have not returned to our plan's service area within six months, you will be disenrolled from our plan.</p> <p>When receiving emergency services <u>outside the United States and its territories (worldwide coverage)</u> you will be responsible for \$125 per incident. Please note, once you transfer out of the emergency department, Network Health will no longer pay for services, including if you remain inpatient in a hospital. Network Health Cares will pay the remaining cost per incident up to the maximum \$100,000 every year. For example, if you require urgent care services that span two calendar years (December to January) the maximum covered amount is \$100,000. 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.*</p> <p>Note: Wisconsin Medicaid may not have coverage outside the state of Wisconsin.</p>	

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


Covered Service	What you pay
<p>Fitness program with One Pass™</p> <p>Your fitness program includes access to fitness centers, in-person and online fitness events and fitness classes for all levels. Your fitness program travels with you, with on-demand digital fitness classes, more</p>	<p>In-Network</p> <p>\$0 when using your fitness program.</p>

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

Covered Service	What you pay
<p>than 24,000 virtual classes and more than 28,000 fitness center locations nationwide.</p> <p>Visit networkhealth.com/medicare/extra-benefits-snp for more information.</p>	<p>Out-of-Network</p> <p>When going to a non-contracted health club facility, fitness center membership charges will apply. We do not reimburse for these fees.</p>
<p>Fresh produce or pantry box delivery benefit</p> <p>Network Health Cares (PPO D-SNP) members that work with a care manager and have been diagnosed with diabetes, congestive heart failure or obesity may be eligible to receive produce or pantry boxes for delivery, up to six boxes per calendar year.</p> <p>Your food box delivery benefit is administered by Mom’s Meals. Contact your Care Manager at 866-709-0019 to learn more about home-delivered boxes.</p>	<p>In-Network</p> <p>0% of the allowed amount of home-delivered food boxes.</p> <p>Out-of-Network</p> <p>Boxes must be provided by our plan’s approved partner. We do not reimburse for home-delivered boxes provided by other services.</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p>	<p>Cost sharing and deductibles for Medicare-covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered hearing exam.</p>

Covered Service	What you pay
<p>Hearing services – extra benefits*</p> <p>We also cover hearing services not covered by Original Medicare. We cover:</p> <ul style="list-style-type: none"> • Hearing aids, up to one per ear each calendar year. Choose from a wide selection of quality, brand name hearing aids. A hearing exam is required to purchase a hearing aid and must be scheduled through our approved vendor, TruHearing. A hearing aid fitting is included with purchase of a hearing aid. Hearing aids are only covered when purchased through our plan's approved vendor, TruHearing. • One non-Medicare covered routine hearing exam per calendar year is covered. <p>To learn more about how to use your hearing aid and routine hearing exam benefits, visit networkhealth.com/medicare/extra-benefits-snp.</p> <p>Note: Our provider network for hearing aids and routine hearing exams is different than our provider network for medical hearing services. For more information and to find a provider, visit networkhealth.com/medicare/extra-benefits-snp.</p> <p>Note: We recommend checking your Medicaid hearing benefit prior to using this benefit. Medicaid may cover a hearing exam and hearing aids.</p> <p>If you choose to use an out-of-network provider for your routine hearing exam, our plan will pay up to the maximum in-network provider fee schedule. You will be responsible for any difference between the maximum fee schedule, and the amount charged by your provider.</p>	<p>In-Network</p> <p>\$495 to \$1,695 per hearing aid through our approved vendor, TruHearing.</p> <p>\$0 copayment for each non-Medicare covered routine hearing exam.</p> <p>Out-of-Network</p> <p>Hearing aid discount is only available through our approved vendor, TruHearing.</p> <p>\$40 for a non-Medicare covered routine hearing exam.</p>

*Your cost for hearing aids and non-Medicare covered routine hearing exam *doesn't* apply toward the annual out-pocket maximum.

Covered Service	What you pay
<p>Help with Certain Chronic Conditions - Acupuncture and Transportation</p> <p>Acupuncture</p> <ul style="list-style-type: none"> Up to 12 visits per year are covered for members who are undergoing chemotherapy and experiencing severe nausea. <p>Transportation</p> <ul style="list-style-type: none"> Up to 24 one-way trips per year for members diagnosed with End-Stage Renal Disease to get to and from dialysis for treatment. Contact Aryv to schedule/cancel your ride at 855-923-1113 (TTY 711) or visit aryv.com/network-health. To cancel your ride, please do so during business hours no less than 24 hours in advance of your scheduled ride. <p>Note: This is a Special Supplemental Benefit for the Chronically Ill (SSBCI) benefit. In addition to an eligible chronic condition, members must also meet additional eligibility requirements to receive the SSBCI benefit.</p>	<p>In-Network \$0 copayment for each acupuncture treatment.</p> <p>\$0 copayment for each one-way transportation for dialysis treatment.</p> <p>Out-of-Network \$0 copayment for each acupuncture treatment.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> One screening exam every 12 months <p>If you're pregnant, we cover:</p> <ul style="list-style-type: none"> Up to three screening exams during a pregnancy 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network There is no coinsurance, copayment or deductible for members eligible for Medicare-covered preventive HIV screening.</p> <p>Out-of-Network 0% to 20% of the allowed amount for members eligible for Medicare-covered preventive HIV screening.</p>

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

Covered Service	What you pay
<p>Home health agency care</p> <p>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ Physical, occupational and speech therapy services provided by an outpatient provider while you're 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 	<p>Cost sharing for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>\$0 copayment for each Medicare-covered home health visit.</p>
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier <p>Note: If additional services are performed and the cost sharing for those services aren't listed here, they will be subject to the cost sharing described elsewhere in this chart.</p>	<p>In- and Out-of-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>\$0 copayment for Medicare-covered home health visit.</p> <p>0% to 20% of the allowed amount for each Medicare-covered Part B home infusion drug.</p> <p>0% to 20% of the allowed amount for each Medicare-covered durable medical service or item for home infusion therapy.</p>
<p>Hospice care</p> <p>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area,</p>	<p>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</p>

Covered Service	What you pay
<p>including programs we own, control, or have a financial interest in. Your hospice doctor can be an in-network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</p> <p>For hospice services and services that are covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p>For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization).</p> <ul style="list-style-type: none"> • If you get the covered services from an in-network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare <p>For services covered by Network Health Cares but are not covered by Medicare Part A or B: Network Health Cares will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.</p> <p>For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, got to Chapter 5, Section 9.4</p> <p>Note: If you need non-hospice care (care that's not related to your terminal prognosis), 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.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>Original Medicare, not Network Health Cares.</p> <p>In- and Out-of-Network</p> <p>\$0 copayment for hospice consultation.</p>

Covered Service	What you pay
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* Your cost sharing for services covered by Original Medicare do not apply toward the annual out-of-pocket maximum.

 **Immunizations**

Covered Medicare Part B services include:

- Pneumonia vaccines
- Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary
- *Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B*
- COVID-19 vaccines
- Other vaccines if you're at risk and they meet Medicare Part B coverage rules such as tetanus, or tetanus, diphtheria and pertussis or tetanus and diphtheria - when related to the **treatment of an injury or direct exposure** to a disease or condition.

Immunizations are generally covered under Medicare Part B if they are being administered for medical treatment or in relation to an injury. We also cover most other adult vaccines under your Part D drug benefit. Go to Chapter 6, Section 7 for additional information.

Note: Some vaccines are covered under Part D whether you get them at the pharmacy or at your doctor's office. If you get your Part D vaccine at the pharmacy, you will pay less out-of-pocket up front. If you get your Part D vaccine at the doctor's office, you will have to pay for the vaccine out-of-pocket and ask us to reimburse you. Go to Chapter 6, Section 7 for additional information.

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

In-Network

There is no coinsurance, copayment or deductible for the pneumonia, flu/influenza and COVID-19 vaccines.

\$0 copayment for *Hepatitis B* and all other Medicare Part B covered immunizations.

Out-of-Network

There is no coinsurance, copayment or deductible for the pneumonia, Flu/influenza and COVID-19 vaccines.

0% to 20% of the allowed amount for *Hepatitis B* and all other Medicare Part B covered immunizations.

In-Home support services

In-home support may include household tasks, technology help, transportation, shopping and meal preparation.

You receive 120 hours per year of in-home support services.

Care managers will coordinate with members needing assistance. Contact your Care Manager at 866-709-0019 (TTY 711) to learn more about in-home support services.

Visit networkhealth.com/medicare/extra-benefits-snp for more details about this benefit.

Note: Medical care, personal care or support activities of daily living such as bathing, medication administration, dressing, toileting, brushing teeth and feeding are excluded. House tasks such as cleaning that you would pay a professional to do are excluded.

In-Network

0% of the allowed amount for in-home support services. after deductible.

Out-of-Network

Services must be provided by our plan's approved vendor. We do not reimburse in-home support services provided by other providers. after deductible.

Inpatient hospital care

Per admission you pay

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**Covered Service**

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Covered services include but aren't limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If 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 Health Cares 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 Health Cares service area and in the Madison or Milwaukee metropolitan areas are considered within the normal community patterns of care. Indiana University Health is also considered in the normal community patterns of care for intestinal transplants only.

Transportation and lodging are covered up to \$5,000 each plan year.

- Only travel and lodging expenses incurred during the period that begins with the first date of service for the transplant and ending 180 days after the transplant are covered.
- Lodging reimbursement is limited to the United States General Services Administration per diem rate.

What you pay**In- and Out-of-Network**

All In-Network hospital inpatient services, including medical, surgical, behavioral health and rehabilitation require that your provider notify us in advance (prior approval). Please have your provider contact our plan for more details.

In 2025 the amounts for each admission were \$0 or up to:

1. Days 1-60:
\$1,676 deductible. +
2. Days 61-90:
\$419 per day. +
3. Days 91-150:
\$838 per lifetime reserve day. +

+ these amounts may change for 2026.

You will not be charged additional cost sharing for professional services.

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 an in-network hospital. Please refer to Chapter 3, Section 3 for additional information.

Covered Service

What you pay

- Mileage reimbursement is limited to the Internal Revenue Service medical rate.
- Only the following types of travel expenses are reimbursable: auto mileage, economy class airfare, train fare, parking, tolls and shuttle/bus fare.

Note: Only the cost of transportation between the member's residence located in Network Health Cares service area to the designated transplant facility and between the lodging facility and transplant facility is reimbursable. You will be reimbursed for traveling and lodging only if all these criteria are met:

- o You submit all necessary documentation (such as receipts, lodging verification, etc.) to this address:

Network Health Medicare Advantage Plans
PO Box 120
1570 Midway Pl.
Menasha, WI 54952

- o You receive services outside the community pattern of care. Which excludes facilities located within the service area, Madison or Milwaukee metropolitan area. For intestinal transplants, Indiana University Health is considered in the normal community patterns of care.
- Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint.
- Physician services

Note: Over-the-counter (OTC) medications that you receive in an inpatient setting are not covered.

Note: To be inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. You're inpatient starting the day you're formally admitted to the hospital with a doctor's order and the day before you're 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're discharged before midnight on your last day, then that day doesn't count toward the total days.

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

Covered Service	What you pay
<p>Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay. You get up to 190 days in an inpatient psychiatric hospital in a lifetime. The 190-day limit doesn't apply to the inpatient mental health services provided in a psychiatric unit of a general hospital.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximums.</p> <p>Per admission you pay</p> <p>In- and Out-of-Network</p> <p><i>Except in an emergency, your doctor must tell our plan you're going to be admitted to the hospital.</i></p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>In 2025 the amounts for each admission were \$0 or up to:</p> <ul style="list-style-type: none"> • Days 1-60: \$1,676 deductible. + • Days 61-90: \$419 per day. + • Days 91-190: \$838 per lifetime reserve day. + <p>+ These amounts may change for 2026.</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Lifetime reserve days can only be used once.</p>

Chapter 4 Medical Benefits Chart (what is covered and what you pay)**Covered Service****What you pay****Inpatient stay: Covered services you get in a hospital or skilled nursing facility during a non-covered inpatient stay**

If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:

- Physician services
- Diagnostic tests (like lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy and occupational therapy

Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.

In- and Out-of-Network

In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.

0% to 20% of the allowed amount for each Medicare covered PCP visit.

0% to 20% of the allowed amount for each Medicare-covered specialist visit.

0% to 20% of the allowed amount coinsurance for each Medicare-covered diagnostic procedure, test and/or lab service.

0% to 20% of the allowed amount for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test.



0% to 20% of the allowed amount for each Medicare-covered X-ray service.

0% to 20% of the allowed amount for each Medicare-covered radiation therapy service.

0% to 20% of the allowed amount for each Medicare-covered diagnostic radiology, PET, CAT, MRI, MRA, or NUC service.

0% to 20% of the allowed amount for each Medicare-covered prosthetic, orthotic device or durable medical equipment.

0% to 20% of the allowed amount for each Medicare-covered physical therapy, speech therapy or occupational visit.

Covered Service	What you pay
<p>Meal Delivery Benefit</p> <p>We cover up to 28 home-delivered meals for eligible members who have been recently discharged from a qualified inpatient hospital stay, hospital observation stay, or a skilled nursing facility stay. Heart-healthy, puree and other dietary-specific meal types are available.</p> <p>Your meal delivery benefit is administered by Mom’s Meals. Contact your Care Manager within seven days of your discharge at 866-709- 0019 to learn more about home-delivered meals.</p>	<p>In-Network 0% of the allowed amount of home-delivered meals.</p> <p>Out-of-Network Meals must be provided by our plan’s approved partner. We do not reimburse for home-delivered meals provided by other services.</p>
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum</p> <p>In-Network There is no coinsurance, copayment or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p>Out-of-Network 0% to 20% of the allowed amount for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services are covered for eligible people under all Medicare health plans.</p> <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network There is no coinsurance, copayment or deductible for the MDPP benefit.</p> <p>Out-of-Network 0% to 20% of the allowed amount for members eligible for the MDPP benefit.</p>
<p>Medicare Part B drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>Most drugs are not covered under Part B. Brand Medicare Part B</p>


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

Covered Service	What you pay
<ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary traditional insulin pump that uses tubing, like Medtronic and Tandem) is covered under Medicare Part B. Insulin furnished through a tubeless insulin pump, such as Omnipod, is covered under the Part D prescription drug benefit. • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Part B 	<p>medications with a generic available may not be covered.</p> <p>Certain Part B drugs may require step therapy. In addition to the Part B 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 drug is administered.</p> <p>In- and Out-of-Network</p> <p><i>Medications under Medicare Part B and Part B chemotherapy medications given in an In-Network physician's office require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount for each Medicare-covered Part B or chemotherapy drug. Part B rebatable drugs will not exceed the coinsurance amount of the original Medicare adjusted coinsurance for the Part B rebatable drug. Insulin cost sharing is the lesser of 20% or \$35 per one-month supply. Our plan deductible doesn't apply.</p>

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

Covered Service	What you pay
<ul style="list-style-type: none"> • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics. • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) • Certain Part B drugs are subject to step therapy. These categories are: Alpha-1 Proteinase Inhibitor, Bevacizumab, Botulinum Toxins, Colony Stimulating Factors-filgrastims, Colony Stimulating Factors-pegfilgrastims, Erythroid Stimulating Agents, Immunologicals, Inflammatory Conditions, Inflammatory Conditions-Infliximab Products, Inflammatory Conditions-Tocilizumab Products, Inflammatory Conditions-Ustekinumab Products, IV Iron Replacement Products, Enzyme Replacement Products, Migraines, Neurology-Eculizumab Products, Ophthalmic VEGF Products, Paroxysmal Nocturnal Hemoglobinuria, Rituximab Products, and Trastuzumab Products. The categories are subject to change throughout the year. Use the following link to take you to a list of the most recent Part B drugs that may be subject to step therapy: networkhealth.com/medicare/pharmacy-information. <p>We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit.</p> <p>Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.</p>	

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

Covered Service	What you pay
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for preventive obesity screening and therapy.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for preventive obesity screening and therapy.</p>
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered opioid treatment program services</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount coinsurance for each Medicare-covered diagnostic procedure, test and/or lab service.</p>

Covered Service	What you pay
<ul style="list-style-type: none"> • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Diagnostic mammograms • Other outpatient diagnostic tests 	<p>0% to 20% of the allowed amount for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test.</p> <p>0% to 20% of the allowed amount for each Medicare-covered X-ray or diagnostic mammogram service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered radiation therapy service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered diagnostic radiology MRI, MRA, PET, CAT or NUC service</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you’re an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren’t sure if you’re an outpatient, ask the hospital staff.</p> <p>Note: Medicare Part B generally doesn’t pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in an outpatient setting. Self-administered drugs may be covered under your Part D benefit; however, there is no Part D coverage for over-the-counter medications.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered outpatient hospital observation.</p>

Covered Service	What you pay
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself <p>Note: Medicare Part B generally doesn't pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in an outpatient setting. Self-administered drugs may be covered under your Part D benefit; however, there is no Part D coverage for over-the-counter medications.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient, ask the hospital staff.</p> <p>Get more information in a Medicare fact sheet <i>Medicare Hospital Benefit</i>. This fact sheet is available at www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p><i>In-Network services including some outpatient surgeries may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount coinsurance for each Medicare-covered diagnostic procedure, test and/or lab service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered ultrasound, EKG, EEG, echocardiogram or stress test.</p> <p>0% to 20% of the allowed amount for each Medicare-covered X-ray or diagnostic mammogram service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered radiation therapy service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered diagnostic radiology MRI, MRA, PET, CAT or NUC service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered Part B and chemotherapy drug.</p> <p>0% to 20% of the allowed amount for each Medicare-covered partial hospitalization service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered outpatient hospital visit.</p>

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

Covered Service	What you pay
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered outpatient mental health individual or group therapy visit.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.)</i></p> <p>0% to 20% of the allowed amount for each Medicare-covered occupational therapy visit.</p> <p>0% to 20% of the allowed amount for each Medicare-covered physical therapy and speech and language therapy visit.</p>
<p>Outpatient substance use disorder services</p> <p>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.</p> <p>Medicare covers substance abuse treatment in an outpatient treatment center if the center has agreed to participate in the Medicare program.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>You pay 100% for third party requests or required (i.e., employment, foster, grandparent, or court-ordered) physicals, exams and related services.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered individual or group therapy substance abuse visit.</p>

Covered Service	What you pay
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p> <p>Note: Medicare Part B generally doesn't pay for self-administered drugs (SADs) or over-the-counter (OTC) medications that you receive in an outpatient setting. Self-administered drugs may be covered under your Part D benefit; however, there is no Part D coverage for over-the-counter medications.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount for each Medicare-covered outpatient hospital visit.</p> <p>0% to 20% of the allowed amount for each Medicare-covered ambulatory surgical center visit.</p>
<p>Over-the-counter (OTC) catalog</p> <p>Our plan offers a \$280 quarterly allowance, that can be used to purchase qualified over-the-counter (OTC) items from our mail-order service. Each \$280 quarterly benefit will be available January 1 – March 31, April 1 – June 30, July 1 – September 30 and October 1 – December 31. Unused funds will expire after each quarter. You may place up to two orders per quarter. We do not reimburse OTC items purchased from retail stores or other mail-order services.</p> <p>OTC services are administered by Convey, Inc. For more information on how to use your \$280 quarterly allowance, visit networkhealth.com/medicare/extra-benefits-snp or log into the member portal at login.networkhealth.com.</p>	<p>In-Network</p> <p>\$0 copayment of qualified OTC items, up to the \$280 quarterly maximum.</p> <p>Out-of-Network</p> <p>OTC items must be ordered from our plan's approved catalog. We do not reimburse for OTC items purchased from retail stores or other mail-order services</p>



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

Covered Service	What you pay
<p>Partial hospitalization services and Intensive outpatient services <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p> <p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p>	<p>Cost sharing for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network 0% to 20% of the allowed amount for each Medicare-covered partial hospitalization or intensive outpatient service.</p>


Covered Service	What you pay
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically necessary medical care or surgery services you get in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Palliative care services • Basic hearing and balance exams performed by your PCP <i>or</i> 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. <ul style="list-style-type: none"> ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use an in-network provider who offers the service by telehealth. ○ 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. • Telehealth services (excluding behavioral health and dermatology) received from our partner, MDLIVE, have a \$0 copayment. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member’s home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ○ You have an in-person visit within six months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ You’re not a new patient and ○ The check-in isn’t related to an office visit in the past seven days and 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount for each Medicare-covered PCP office or telehealth visit.</p> <p>0% to 20% of the allowed amount for each Medicare-covered specialist office or telehealth visit.</p> <p>0% to 20% of the allowed amount for each Medicare-covered hearing exam after deductible.</p> <p>0% to 20% of the allowed amount for each Medicare-covered dental service.</p> <p>0% to 20% of the allowed amount for each Medicare-covered mental health office or telehealth visit.</p> <p>0% to 20% of the allowed amount for remote patient monitor set up and ongoing monitoring (in-network only).</p>



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

Covered Service	What you pay
<ul style="list-style-type: none"> ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment ● Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ○ You're not a new patient and ○ The evaluation isn't related to an office visit in the past seven days and ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment ● Consultation your doctor has with other doctors by phone, internet, or electronic health record ● Second opinion prior to surgery ● 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) ● Initial and ongoing remote patient monitoring in an in-network setting or prescribed by an in-network PCP <p>Note: If you receive Practitioner/Provider services through telehealth from your provider, you will pay the same amount as if you visited the provider in-person.</p>	
Covered Service	What you pay
<p>Podiatry services Covered services include:</p> <ul style="list-style-type: none"> ● 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 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>You pay 100% for nail trimming unless performed as a qualified diabetic service.</p> <p>In- and Out-of-Network 0% to 20% of the allowed amount for each Medicare-covered podiatry visit.</p>


Covered Service	What you pay
<p> Pre-exposure prophylaxis (PrEP) for HIV prevention</p> <p>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. <p>A one-time hepatitis B virus screening.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for the PrEP benefit.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for members eligible for this preventive benefit.</p>
<p> Prostate cancer screening exams</p> <p>For men aged 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for an annual PSA test.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for members eligible for this preventive benefit.</p>
<p>Prosthetic and orthotic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but aren't limited to, testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to Vision care later in this section for more detail.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount for each Medicare-covered item.</p>


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

Covered Service	What you pay
<p>Pulmonary rehabilitation services</p> <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network 0% to 20% of the allowed amount for each Medicare-covered pulmonary rehabilitation service.</p>
<p>Remote access care resources</p> <p>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.</p> <p>Visit networkhealth.com/wellness/getting-care-quickly to learn more about your resources.</p> <p>Note: Services through MDLIVE (excluding behavioral health and dermatology) have a 0% cost share. Services provided by other practitioners will follow cost sharing that is outlined in this Medical Benefits Chart.</p>	<p>In- and Out-of-Network 0% of the allowed amount for these services.</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network There is no coinsurance, copayment or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> <p>Out-of-Network 0% to 20% of the allowed amount for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>

Covered Service	What you pay
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified people, a LDCT is covered every 12 months.</p> <p>Eligible members are: people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get 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.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must get 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for each member eligible for this preventive benefit.</p>
<p> Screening for Hepatitis C Virus infection</p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> • You’re at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. <p>If you were born between 1945-1965 and aren’t considered high risk, we pay for a screening once. If you’re at high risk (for example, you’ve continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for the Medicare-covered screening for the Hepatitis C Virus.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for each member eligible for this preventive benefit.</p>

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

Covered Service	What you pay
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>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.</p> <p>We also cover up to two people 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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p> <p>Out-of-Network</p> <p>0% to 20% of the allowed amount for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in advance). Please have your provider contact our plan for more details.</i></p> <p>0% to 20% of the allowed amount Medicare-covered renal dialysis or kidney disease education.</p> <p>0% to 20% of the allowed amount for each Medicare-covered durable medical service or item.</p>
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)</p>	<p>In- and Out-of-Network</p> <p><i>In-Network services may require that your provider get prior authorization (approval in</i></p>

Covered Service	What you pay
<p>We will cover skilled care only if the following is true:</p> <ul style="list-style-type: none"> The planned care at the skilled nursing facility meets Medicare’s definition of medical necessity. <p>You’re covered for up to 100 days (facility transfers are not considered a new admission). Covered services include but aren’t limited to:</p> <ul style="list-style-type: none"> Semiprivate room (or a private room if medically necessary) Meals, including special diets Skilled nursing services Physical therapy, occupational therapy and speech therapy Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. Medical and surgical supplies ordinarily provided by 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 <p>Generally, you get skilled nursing facility care from In-network facilities. 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.</p> <ul style="list-style-type: none"> 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 or domestic partner is living at the time you leave the hospital 	<p><i>advance). Please have your provider contact our plan for more details.</i></p> <p>In 2025, the amounts for each admission were \$0 or up to:</p> <ul style="list-style-type: none"> Days 1-20 \$0 per day. + Days 21-100 \$209.50 per day. + <p>+These amounts may change for 2026.</p> <p>You will not be charged additional cost sharing for professional services.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease Are competent and alert during counseling 	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p>


Covered Service	What you pay
<ul style="list-style-type: none"> A qualified physician or other Medicare-recognized practitioner provides counseling <p>We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with the patient getting up to eight sessions per year).</p>	<p>There is no coinsurance, copayment or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <p>Out-of-Network 0% to 20% of the allowed amount for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>Supervised exercise therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> 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 <p>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.</p>	<p>Cost sharing and deductibles for covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network 0% to 20% of the allowed amount for each Medicare-covered supervised exercise therapy session.</p>
<p>Transportation Benefit (non-emergency)</p> <p>Your plan covers 52 one-way trips per year to and from approved locations within our plan’s service area. A trip is considered one-way, a round trip is considered two trips. Wheelchair accessible vehicles may be available upon request.</p> <p>Approved locations include:</p> <ul style="list-style-type: none"> Medical and dental appointments Pharmacies Fitness centers 	<p>In-Network 0% of the cost of eligible trips.</p> <p>Out-of-Network Transportation must be provided by our plan’s approved partner. We do not reimburse for non-emergency transportation provided by other services.</p>

Covered Service	What you pay
<ul style="list-style-type: none"> • Grocery stores • Senior centers and local ADRC offices • Health and wellness classes <p>Your transportation benefit is administered by Aryv. Contact your Care Manager at 866-709-0019 to learn more about your non-emergency transportation benefit.</p> <p>Note: If you need to cancel your ride, please do so by contacting Aryv at 855-923-1113 (TTY users calls 711) during business hours no less than 24 hours in advance of your scheduled ride.</p>	
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plan’s service area, or, even if you’re inside our plan’s service area, it’s unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Note: It is 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. Our plan will pay the provider the Medicare-approved amount for charges, minus your applicable cost sharing.</p> <p>Note: If you’re in the visitor/traveler area, you can stay enrolled in our plan for up to six months. If you have not returned to our plan’s service area within six months, you will be disenrolled from our plan.</p> <p>When receiving urgently needed services <u>outside the United States and its territories (worldwide coverage)</u> you will be responsible for \$125 per incident. Please note, once you transfer out of the emergency department, Network Health will no longer pay for services, including if you remain inpatient in a hospital. Network Health Cares will pay the remaining cost per incident up to the maximum \$100,000 every year. For example, if you require urgent care services that span two</p>	<p>Cost sharing and deductibles for covered services within the United States and its territories apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network</p> <p>0% to 20% of the allowed amount (up to \$40) for each Medicare-covered urgently needed care visit within the United States and its territories.</p> <p>\$125 per incident for each non-Medicare covered urgently needed care visit outside the United States and its territories.</p>

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


Covered Service	What you pay
<p>calendar years (December to January) the maximum covered amount is \$100,000. 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.*</p> <p>Note: Wisconsin Medicaid may not have coverage outside the state of Wisconsin.</p>	

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

Covered Service	What you pay
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have two separate cataract operations, you can't reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant are not covered. Tinting, scratch protection or other enhancements to the eyewear are also not covered. <p>Note: Cataract surgery may have the outpatient hospital or Ambulatory Surgical Center copayment. Please see Outpatient hospital services.</p> <p>Note: Only the conventional intraocular lens is covered with either the blade or laser removal of a cataract. Insertion of lenses to correct vision are not covered.</p> <p>Note: Diagnostic testing copayments may apply. Please see Outpatient Diagnostic Testing for more information.</p> <p>Note: Eye refraction performed in conjunction with Medicare-covered eye exams are not covered by Network Health but are eligible for coordination of benefits. See Vision care - extra benefits for more details.</p>	<p>Cost sharing and deductibles for Medicare-covered services apply toward the annual out-of-pocket maximum.</p> <p>In- and Out-of-Network 0% to 20% of the allowed amount for each Medicare-covered preventive glaucoma test.</p> <p>0% to 20% of the allowed amount for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.</p> <p>0% to 20% of the allowed amount for each Medicare-covered eyewear (one pair of eyeglasses or 12 pairs of contact lenses after each cataract surgery).</p>
<p>Vision care – extra benefits*</p> <p>We also cover routine vision services not covered by Original Medicare. We cover:</p> <ul style="list-style-type: none"> • One non-Medicare covered routine vision exam per calendar year including refraction. Refraction is covered when billed in conjunction with the routine vision exam or with coordination of benefits when billed in conjunction with a medical vision exam. 	<p>Allowance of \$400 toward non-Medicare covered eyewear (such as eyeglass frames and lenses and/or contact lenses annually).</p> <p>In-Network \$0 copayment for each non-Medicare covered routine vision exam.</p>

Covered Service	What you pay
<ul style="list-style-type: none"> Any other vision services, such as physician services for the diagnosis and treatment of diseases and/or injuries of the eye, are not included in the routine vision exam. An allowance of \$400 toward non-Medicare covered eyeglasses (lenses and frames) and/or contact lenses each calendar year, with a valid prescription. <p>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® and must be performed by a provider in EyeMed’s network. For more information and a link to the provider search, visit networkhealth.com/medicare/extra-benefits-snp.</p>	<p>Out-of-Network</p> <p>Reimbursement up to a maximum of \$40 for each non-Medicare covered routine vision exam.</p>

* Your cost sharing and deductibles for non-Medicare-covered services doesn’t apply toward the annual out-of-pocket maximum.

Covered Service	What you pay
<p> Welcome to Medicare preventive visit</p> <p>Our plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you want to schedule your Welcome to Medicare preventive visit.</p>	<p>Cost sharing and deductibles for Medicare-covered services apply toward the annual out-of-pocket maximum.</p> <p>In-Network</p> <p>There is no coinsurance, copayment or deductible for the Welcome to Medicare preventive visit.</p> <p>Out-of-Network 0% to 20% of the allowed amount for members eligible for this preventive benefit.</p>

Section 2.1 Get care using our plan’s optional visitor/traveler benefit

If you don’t permanently move, but you’re continuously away from our plan’s service area for more than six months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program which includes all U.S. territories and remaining 49 states outside Wisconsin, which will allow you to stay enrolled in our plan when you’re outside of our service area for less than 12 months. Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Contact our plan for help in locating a provider when using the visitor/traveler benefit.

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

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

Note: It is 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. Our plan will pay the provider the Medicare-approved amount for charges, minus your applicable cost sharing.

Note: If you're in the visitor/traveler area, you can stay enrolled in our plan for up to six months. If you don't return to our plan's service area within six months, you'll be disenrolled from our plan.

When receiving emergency or urgently needed services **outside the United States and its territories (worldwide coverage)** you will be responsible for \$125 per incident. Please note, once you transfer out of the emergency department, Network Health will no longer pay for services, including if you remain inpatient in a hospital. Network Health Cares will pay the remaining cost per incident up to the maximum \$100,000 every year. For example, if you require urgent care services that span two calendar years (December to January) the maximum covered amount is \$100,000. 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.

Note: Wisconsin Medicaid may not have coverage outside of the State of Wisconsin.

SECTION 3 Services covered outside of Network Health Cares

The following services aren't covered by Network Health Cares but are available through Medicaid:

- Family planning services and supplies
- Some home and community-based services
- Intermediate care facility services, other than services at an institution for mental disease
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Personal care services

SECTION 4 Services that aren't covered by our plan

Section 4.1 Services *not* covered by our plan (exclusions)

This section tells you what services are excluded.

The chart below list services and items that aren't covered by our plan under any conditions or are covered by our plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific

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

conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3.)

Services not covered by Medicare	Covered only under specific conditions
<p>Acupuncture</p>	<p>Available for people with chronic low back pain under certain circumstances.</p> <p>Acupuncture may be covered for members who are undergoing chemotherapy and experiencing severe nausea. Please refer to the Medical Benefits Chart for additional information.</p>
<p>Cosmetic surgery or procedures</p>	<p>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</p> <p>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</p>
<p>Custodial care</p> <p>Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>	<p>Not covered under any condition</p>
<p>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.</p>	<p>May be covered if medically necessary</p>
<p>Experimental medical and surgical procedures, equipment and medications</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>	<p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(Go to Chapter 3, Section 5 for more information on clinical research studies.)</p>
<p>Fees charged for care by your immediate relatives or members of your household</p>	<p>Not covered under any condition</p>
<p>Full-time nursing care in your home</p>	<p>Not covered under any condition</p>

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

Services not covered by Medicare	Covered only under specific conditions
Homemaker services include basic household help, including light housekeeping or light meal preparation	Homemaker services may be covered. Please refer to the In-Home Support benefit in the Medical Benefits Chart for additional information.
Maintenance chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.
Naturopath services (uses natural or alternative treatments).	Not covered under any condition
Non-emergency transportation	Non-emergency transportation may be covered. Please refer to the Transportation Benefit (non-emergency) benefit in the Medical Benefits Chart for additional information.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Outpatient Part D prescription drugs, including drugs for treatment of sexual dysfunction, such as erectile dysfunction, impotence and anorgasmy or hyporgasmy.	Not covered under any condition
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Prescriptions or refill of prescriptions that are lost, stolen or damaged	Not covered under any condition
Private duty nurses	Not covered under any condition
Private room in a hospital	Covered only when medically necessary.
Residential AODA and mental health treatment	Not covered under any condition
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	Eye exam and one pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens. Routine vision exams covered once per year. Refraction is only covered when performed with a routine vision exam. Additional eyewear is also covered. Please refer to the Vision care and Vision care - extra benefits in the Medical Benefits Chart for additional information
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).

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

Services not covered by Medicare	Covered only under specific conditions
Routine hearing exams, hearing aids, or exams to fit hearing aids	<p>Hearing aids are covered. Routine hearing exams and hearing aid fittings are covered with the purchase of a hearing aid. Routine hearing exams are covered and may have a copayment, depending on where you obtain the service.</p> <p>Please refer to the Hearing services – extra benefits benefit in the Medical Benefits Chart for additional information.</p>
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Services provided to veterans in Veterans Affairs (VA) facilities	Emergency services that are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
Surgical treatment for morbid obesity	Covered only when medically necessary and covered under Original Medicare.

CHAPTER 5:

Using plan coverage for Part D drugs

How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call our member experience team at 855-653-4363 (TTY users call 711) and ask for the *LIS Rider*. (Phone numbers for our member experience team are printed on the back cover of this document.)

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. Call Wisconsin Medicaid for information about Medicaid drug coverage. (Please see Chapter 2, Section 6 for contact information.)

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use an in-network pharmacy to fill your prescription (Go to Section 2) or you can fill your prescription through our plan's mail-order service.
- Your drug must be on our plan's Drug List. (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

SECTION 2 Fill your prescription at an in-network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered *only* if they're filled at our plan's in-network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

An in-network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term covered drugs means all the Part D drugs on our plan's Drug List.

Section 2.1 In-network pharmacies

Find an in-network pharmacy in your area

To find an in-network pharmacy, go to your *Pharmacy Directory*, visit our website networkhealth.com/find-a-pharmacy, and/or call our member experience team at 855-653-4363 (TTY users call 711).

You may go to any of our in-network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from our member experience team at 855-653-4363 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at networkhealth.com/find-a-pharmacy.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call our member experience team at 855-653-4363 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* networkhealth.com/find-a-pharmacy or call our member experience team at 855-653-4363 (TTY users call 711).

Section 2.2 Our plan's mail-order service

Our plan's mail-order service allows you to order up to a 90-day supply.

To get order forms and information about filling your prescriptions by mail contact home delivery by calling Express Scripts Pharmacy Customer Service at 800-316-3107 (TTY user call 800-716-3231). If you use a mail-order pharmacy not in our plan's network, your prescriptions may not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days from when Express Scripts pharmacy receives your prescription. However, sometimes your mail-order may be delayed. If your order cannot be delivered within 14 days, an Express Scripts representative may contact you. If you need

your prescriptions immediately, reach out to your provider to obtain a prescription at an in-network retail pharmacy to get a small supply to last until your mail-order prescription arrives.

New prescriptions the pharmacy gets directly from your doctor's office.

The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You can ask for automatic delivery of all new prescriptions at any time by having your provider submit a prescription on your behalf. The provider can send a prescription to Express Scripts electronically or by fax. If you have used mail-order services with this plan in the past, you will automatically be signed up for automatic delivery of all new prescriptions received directly from your health care provider. If you do not have mail-order history, the pharmacy will contact you when it receives the first prescription from your health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to ensure the pharmacy is delivering the correct drug (including strength, amount and form) and, if necessary, allow you to cancel or delay the order before you're billed and it is shipped. It is important to respond to the pharmacy when you're contacted, to let them know what to do with the new prescription and to prevent any delays in shipping. After the first new prescription has been filled, your future prescriptions will automatically be processed and sent to you.

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Express Scripts Customer Service at 800-316-3107 (TTY users call 800-716-3231).

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling Express Scripts Customer Service at 800-316-3107 (TTY users call 800-716-3231).

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 21 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact Express Scripts Customer Service at 800-316-3107 (TTY users call 800-716-3231).

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs at a lower cost-sharing amount. Other retail pharmacies may not agree to the lower cost-sharing amounts. In this case you'll be responsible for the difference in price. Your *Pharmacy Directory* networkhealth.com/find-a-pharmacy tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call our member experience team at 855-653-4363 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use an in-network pharmacy. We also have in-network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with our member experience team at 855-653-4363 (TTY users call 711)** to see if there's an in-network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- You're unable to obtain a covered drug in a timely manner within our service area because there are no in-network pharmacies within a reasonable driving distance that provide 24-hour service.
- You travel outside our service area and cannot access an in-network pharmacy.
- You're trying to fill a prescription that isn't regularly stocked at an accessible in-network retail or mail-order pharmacy (including high-cost and/or unique drugs).
- You're getting a vaccine that is medically necessary but not covered by Medicare Part B.
- You're getting a covered drug that is administered in your doctor's office.
- You were evacuated or displaced from your residence due to a state or federally declared disaster or health emergency.
- You were a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient facility and your medication was dispensed from an out-of-network pharmacy located in one of these institutions.

Out-of-network claims will be covered up to a maximum 30-day supply per claim. More than one out-of-network fill (per drug) may be allowed during the plan year as long as the reason for using an out-of-network pharmacy is based on one of the circumstances listed above and out-of-network filling isn't routine.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be

required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, we call it the **Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List only shows the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. If you have questions about drugs covered under Medicaid, contact Wisconsin Medicaid at 800-362-3002, Monday – Friday, 8 a.m. to 6 p.m.

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug for a medically accepted indication. A medically accepted indication is a use of the drug that's *either*:

- Approved by the FDA for the diagnosis or condition for which prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7).

- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that isn't on our Drug List. (For more information, go to Chapter 9.)
- Some drugs that are not covered under your Medicare plan may be paid for by Wisconsin Medicaid. These drugs are not included on the Drug List. For more information, contact Wisconsin Medicaid to determine if Wisconsin Medicaid will cover the drug. (Go to Chapter 2, Section 6 for contact information.)

Section 3.2 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (networkhealth.com/look-up-medications). The Drug List on the website is always the most current.
- Call our member experience team at 855-653-4363 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's *Real-Time Benefit Tool* (login.networkhealth.com or express-scripts.com/login) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call our member experience team at 855-653-4363 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call our member experience team at 855-653-4363 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling our member experience team at 855-653-4363 (TTY users call 711) or on our website networkhealth.com/look-up-medications.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered in the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug is covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way**.

- **If you're a new member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply. This temporary supply will be for a maximum of a 31-day supply for members residing in a long-term care (LTC) facility. If your

prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply (31-day supply for members residing in an LTC facility) of medication. The prescription must be filled at an in-network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- If you experience a level of care change (for example, are admitted to or discharged from a hospital or long-term care facility), we will not limit your access to appropriate and necessary Part D medication refills. If you need additional medication supplies your pharmacy can obtain an override for this situation to allow for early refills.

For questions about a temporary supply, call our member experience team at 855-653-4363 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call our member experience team at 855-653-4363 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it's not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**

- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
 - We may immediately remove a like drug from the Drug List, add new restrictions or both. The new version of the drug will be added with same or fewer restrictions.
 - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
 - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, add new restrictions or both. The version of the drug that we add will have the same or fewer restrictions.
 - We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
 - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
 - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you take.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. If a drug is excluded, you must pay for it yourself or contact Wisconsin Medicaid for coverage details (please see Chapter 2, section 6 for contact information).

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide your plan membership information (which can be found on your member ID card) at the in-network pharmacy you choose. The in-network pharmacy will automatically bill our plan for our share of the costs of your drug. You'll need to pay the pharmacy *your* share of the cost when you pick up your prescription.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. You will need to provide your Wisconsin Medicaid member ID card at the in-network pharmacy so the pharmacy can bill Wisconsin Medicaid for those prescription drugs.

If you don't have your plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* networkhealth.com/find-a-pharmacy to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call our member experience team at 855-653-4363 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that isn't on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also get drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage would pay first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that's expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up-to-date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call our member experience team at 855-653-4363 (TTY users call 711).

CHAPTER 6: What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan’s *Real-Time Benefit Tool* to look up drug coverage (login.networkhealth.com or express-scripts.com/login) the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided in the *Real-Time Benefit Tool* by calling our member experience team at 855-653-4363 (TTY users call 711).

How can you get information about your drug costs if you’re getting Extra Help with your Part D prescription drugs?

Because you’re eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don’t have this insert, call our member experience team at 855-653-4363 (TTY users call 711) and ask for the *LIS Rider*.

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

There are three different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn’t count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments are included in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they're for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
 - The Deductible Stage
 - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs) and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that aren't covered by our plan.
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA).
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).
- Payments made by drug manufacturers under the Manufacturer Discount Program.

Reminder: If any other organization like the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling member experience team at 855-653-4363 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for Network Health Cares members

There are three **drug payment stages** for your drug coverage under Network Health Cares. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track two types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.

- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your member ID card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
 - When you purchase a covered drug at an in-network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
 - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
 - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
 - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call our member experience team at 855-653-4363 (TTY users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn't apply to most members. If you get Extra Help, this payment stage doesn't apply to you.

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you're in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is \$615 for 2026. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines. **You must pay the full cost of your drugs** until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The **full cost** is usually lower than the

normal full price of the drug since our plan negotiated lower costs for most drugs at in-network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay \$615 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment *or* coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- An in-network retail pharmacy.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* (networkhealth.com/find-a-pharmacy).

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

Sometimes the cost of the drug is lower than your copayment or coinsurance. In these cases, you pay the lower price for the drug instead of the copayment or coinsurance.

Your costs for a one-month supply of a covered Part D drug

Tier	Retail in-network cost sharing (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 31-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost sharing Tier 1 (all drugs)	25%	25%	25%	25%

You won't pay more than the lesser of 25% of the total cost or \$35 for a one-month supply of each covered insulin product, even if you haven't paid your deductible.

Go to Section 7 for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a long-term (up to a 90-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply.

Your costs for a *long-term* (up to a 90-day supply) supply of a covered Part D drug:

Tier	Retail in-network cost sharing (up to a 90-day supply)	Mail-order cost sharing (up to a 90-day supply)
Cost sharing Tier 1 (all drugs)	25%	25%

You won't pay more than the lesser of 25% of the total cost or \$70 for up to a two-month supply or the lesser of 25% of the total cost or \$105 for up to a three-month supply of each covered insulin product, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,100. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* that you get will help you keep track of how much you, our plan and any third parties, have spent on your behalf during the year. Not all members will reach the \$2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket reach the \$2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your Part D drugs.

SECTION 7 What you pay for Part D Vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call our member experience team at 855-653-4363 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depends on three things:

- 1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
 - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
- 2. Where you get the vaccine.**
 - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
- 3. Who gives you the vaccine.**

- A pharmacist or another provider may give the vaccine in the pharmacy. Or, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are three examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the in-network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration) and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Situation 3: You buy the Part D vaccine itself at the in-network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any

coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

Some vaccines are covered under Part D whether you get them at the pharmacy or at your doctor's office, such as vaccines for the prevention of Shingles and Respiratory Syncytial Virus (RSV). It's recommended that you get your Part D vaccines at the pharmacy.

CHAPTER 7:

Asking us to pay our share of a bill for covered medical services or drugs

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

Our in-network providers bill our plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we'll pay the provider directly.

If you have already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called **reimburse** 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 or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. When you got emergency or urgently needed medical care from a provider who's not in our plan's network

You get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.

- If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost for the service, we'll determine how much you owed and pay you back for our share of the cost.

2. When an in-network provider sends you a bill you think you shouldn't pay

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

- You only have to pay your cost-sharing amount when you get covered services. 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's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from an in-network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to an in-network provider, but feel you paid too much, send us the bill along with documentation of any payment you made. Ask us to pay you back for the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

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

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

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have your plan member ID card with you

If you don't have your plan member ID card with you, you can ask the pharmacy to call our plan or look up your plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

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

Note: It is 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. Our plan will pay the provider the Medicare-approved amount for charges, minus your applicable cost sharing.

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

When receiving emergency or urgently needed services **outside the United States and its territories (worldwide coverage)** you will be responsible for \$125 per incident. Please note, once you transfer out of the emergency department, Network Health will no longer pay for services, including if you remain inpatient in a hospital. Network Health Cares will pay the remaining cost per incident up to the maximum \$100,000 every year. For example, if you require urgent care services that span two calendar years (December to January) the maximum covered amount is \$100,000. 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.

Note: Wisconsin Medicaid may not have coverage outside of the State of Wisconsin.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your medical claim to us within 12 months and your prescription drug claims within 36 months** of the date you got the service, item or drug.

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

- You don't have to use the form, but it'll help us process the information faster.

Chapter 7 Asking us to pay our share of a bill for covered medical services or drugs

- Download a copy of the form from our website networkhealth.com or call our member experience team at 855-653-4363 (TTY users call 711) and ask for the form.

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

For Medical Claims

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

For Routine Vision Claims**First American Administrators, Inc.**

Attn: OON Claims

PO Box 8504

Mason, OH 45040-7111

Or online: www.processmyclaim.com/managed-vision-care/member-forms/out-of-network-claim/partner#/

For Prescription Claims

Express Scripts

Attn: Medicare Part D

PO Box 52023

Phoenix, AZ 85072

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement for our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug isn't covered, or you didn't follow all the rules, we won't pay for our share of the cost of the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call our member experience team at 855-653-4363 (TTY users call 711).

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

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

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

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

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

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

You have the right to choose a provider in our plan's network to provide and arrange for your covered services. We don't require you to get referrals to go to in-network providers.

You have the right to get appointments and covered services from our plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our in-network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or

corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, call our member experience team at 855-653-4363 (TTY users call 711).

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

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

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

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

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

If you want any of the following kinds of information, call our member experience team at 855-653-4363 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our in-network providers and our in-network pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **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. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

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

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, from a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call our member experience team at 855-653-4363 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

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

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we're required to treat you fairly.**

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

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

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

- **Call our plan's member experience team at 855-653-4363 (TTY users call 711)**
- **Call your local SHIP** at 1-800-242-1060
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048)

Section 1.9 How to get more information about your rights

Get more information about your rights from these places:

- **Call our member experience team at 855-653-4363 (TTY users call 711)**
- **Call the SHIP** at 1-800-242-1060
- **Contact Medicare.**
 - Visit [Medicare.gov](https://www.medicare.gov) to read the publication *Medicare Rights & Protections* (available at: [Medicare Rights & Protections](#))
 - Or, you can call 1-800-MEDICARE (1-800-633-4227) (TTY users 1-877-486-2048).

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

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

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call our member experience team at 855-653-4363 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
 - Chapters 5 and 6 give details about Part D drug coverage.

- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show your plan member ID card and your Wisconsin Medicaid card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
 - Supply information (to the extent possible) the organization, its practitioners and providers need in order to provide care.
 - Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must pay our plan premiums.
 - You must continue to pay your Medicare premiums to stay a member of our plan.
 - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up-to-date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- If you move, tell Social Security (or the Railroad Retirement Board).

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you'd like help deciding whether to use the Medicare process or the Medicaid process, or both, call our member experience team at 855-653-4363 (TTY users call 711).
2. The type of problem you're having:
 - For some problems, you need to use the **process for coverage decisions and appeals**.
 - For other problems, you need to use the **process for making complaints** (also called grievances).

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

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

Section 1.1 Legal terms

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

However, it's sometimes important – for you to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call our member experience team at 855-653-4363 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

State Health Insurance Assistance Program (SHIP).

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free at Wisconsin SHIP 1-800-242-1060.

Medicare

You can also contact Medicare for help:

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

You can get help and information from Medicaid

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

- Call 800-362-3002 during regular business hours. TTY users should call 888-701-1251.
- Visit the Wisconsin Medicaid website (dhs.wisconsin.gov/medicaid/).

SECTION 3 Which process to use for your problem

Because you have Medicare and get help from Medicaid, you have different processes you can use to handle your problem or complaint. Which process you use depends on if the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, use the Medicare process. If your problem is about a benefit covered by Medicaid, use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, call our member experience team at 855-653-4363 (TTY users call 711).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

Is your problem about Medicare benefits or Medicaid benefits?

My problem is about **Medicare** benefits.

Go to **Section 4, Handling problems about your Medicare benefits.**

My problem is about **Medicaid** coverage.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Go to **Section 12, Handling problems about your Medicaid benefits.**

SECTION 4 Handling problems about your Medicare benefits

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think that you need.

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

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

Making an appeal

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

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7.

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

Section 5.1 Get help asking for a coverage decision or making an appeal

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

- **Call our member experience team at 855-653-4363 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call our member experience team at 855-653-4363 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [networkhealth.com](https://www.networkhealth.com).
 - For medical care, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

- For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your **representative** to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or another person to be your representative, call our member experience team at 855-653-4363 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at networkhealth.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
 - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 5.2 Rules and deadlines for different situations

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

- **Section 6:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 7:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 8:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 9:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call our member experience team at 855-653-4363 (TTY users call 711). You can also get help or information from SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

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

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

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms:

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

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

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service isn't subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 6.3 How to make a Level 1 appeal**Legal terms:**

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

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

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

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

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

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

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

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Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the Independent Review Organization for a Level 2 appeal. The Independent Review Organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get, we'll give you our answer **within seven calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 11 for information on complaints.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an Independent Review Organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within seven calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the Independent Review Organization for a Level 2 appeal.

Section 6.4 The Level 2 appeal process

Legal term:

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

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

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

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

- **If the Independent Review Organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage **within 72 hours** or provide the service within 14 calendar days after we get the decision from the Independent Review Organization's decision for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the Independent Review Organization.
- **If the Independent Review Organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug **within 72 hours** after we get the decision from the Independent Review Organization for **standard requests**. For **expedited requests 24 hours** from the date we get the decision from the Independent Review Organization.

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- **If the Independent Review Organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the Independent Review Organization will send you a letter that:
 - Explains the decision.
 - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage you're requesting meets a certain minimum. The written notice you get from the Independent Review Organization will tell you the dollar amount you must meet to continue the appeals process.
 - Tells you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains the Level 3, 4, and 5 appeals processes.

Section 6.5 If you're asking us to pay you back four our share of a bill you got for medical care

If you have already paid for a Medicaid service or item covered by our plan, ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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To make this appeal, follow the process for appeals in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the Independent Review Organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or *Formulary*.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal term:

An initial coverage decision about your Part D drugs is called a **coverage determination**.

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 Asking for an exception

Legal terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is called a **formulary exception**.

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to all our drugs. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're requesting and wouldn't cause more side effects or other health problems, we generally *won't* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.4 How to ask for a coverage decision, including an exception

Legal term:

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

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet two requirements:

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

- Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which are available on our networkhealth.com. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Step 3: We consider your request and give you our answer.***Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we get your request.
 - For exceptions, we'll give you our answer within 24 hours after we receive your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, 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.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
 - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
 - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**Section 7.5 How to make a Level 1 appeal****Legal terms:**

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**.

A fast appeal is called an **expedited redetermination**.

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

A standard appeal is usually made within seven calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal**.

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 855-653-4363 (TTY 711).** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our networkhealth.com. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request.
- We may contact you or your doctor or other prescriber to get more information.

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Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we have agreed to provide within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within seven calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
 - If we don't give you a decision within seven calendar days, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Section 7.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **seven calendar days** after we receive your 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 and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
 - If we do not meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)**Section 7.6 How to make a Level 2 appeal****Legal term:**

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you'll include **instructions on how to make a Level 2 appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the Independent Review Organization.
- **You must make your appeal request within 65 days** from the date on the written notice.
- If we didn't complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the independent review entity.
- We'll send the information about your appeal to the Independent Review 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.

Step 2: The Independent Review Organization reviews your appeal.

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

Deadlines for fast appeal

- If your health requires it, ask the Independent Review Organization for a fast appeal.
- If the Independent Review Organization agrees to give you a fast appeal, the Independent Review Organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the Independent Review Organization must give you an answer to your Level 2 appeal **within seven calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the Independent

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Review Organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The Independent Review Organization gives you its answer.*For fast appeals:*

- **If the Independent Review Organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the Independent Review Organization **within 24 hours** after we get the decision from the Independent Review Organization.

For standard appeals:

- **If the Independent Review Organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the Independent Review Organization **within 72 hours** after we get the decision from the Independent Review Organization.
- **If the Independent Review Organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the Independent Review Organization.

What if the review organization says no to your appeal?

If the Independent Review Organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the Independent Review Organization will send you a letter that:

- Explains the decision.
- Lets you know of your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 explains the Level 3, 4, and 5 appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within two days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call our member experience team at 855-653-4363 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048).

- 1. Read this notice carefully and ask questions if you don't understand it.** It tells you:
 - Your right to 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.
 - Where to report any concerns you have about the quality of your hospital care.
 - Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
- 2. You'll be asked to sign the written notice to show that you got it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
- 3. Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
 - If you sign the notice more than two calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.

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- To look at a copy of this notice in advance, call our member experience team at 855-653-4363 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227), TTY users call 1-877-486-2048. You can also see the notice online at [CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions call our member experience team at 855-653-4363 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you 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.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do not meet this deadline, contact us.** If 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 get after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you 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 8.3 of this chapter.

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- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling our member experience team at 855-653-4363 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227), (TTY users call 1-877-486-2048.) Or you can see a sample notice online at [CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the Independent Review Organization says yes:

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

If the Independent Review Organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

**Section 9.1 *This section is about three services only:*
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services**

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

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

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

Section 9.2 We'll tell you in advance when your coverage will be ending**Legal term:**

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

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

Section 9.3 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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- **Ask for help if you need it.** If you have questions or need help call our member experience team at 855-653-4363 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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

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

How can you contact this organization?

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

Act quickly:

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

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

Legal term:

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

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 9.4 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the Independent Review Organization says yes?

- **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's medically necessary.

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- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the Independent Review Organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last three levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

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- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept the decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

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

Level 5 appeal

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

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

Section 10.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get 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 as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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Level 3 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **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 don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 11 How to make a complaint about quality of care, waiting times, customer service or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our member experience team? • Do you feel you're being encouraged to leave our plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our member experience team or other staff at our plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the Independent Review Organization; you can make a complaint.

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 11.2 How to make a complaint

Legal terms:

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

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

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

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

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

- **Calling our member experience team at 855-653-4363 (TTY users call 711) is usually the first step.** If there's anything else you need to do, our member experience team will let you know.
 - **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
 - Send your grievance (complaint) in writing to Network Health Medicare Advantage Plans, Attn: Medicare Grievances, PO Box 120, 1570 Midway Pl., Menasha, WI 54952, via fax at 920-720-1832, or phone by calling 855-653-4363 (TTY 711).
 - 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.
 - The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

Chapter 9 If you have a problem or complaint (coverage decisions, appeals, complaints)

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

Or

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

Section 11.4 You can also tell Medicare about your complaint

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

Problems about your Medicaid benefits

SECTION 12 Handling problems about your Medicaid benefits

For more information and help handling a problem with your Wisconsin Medicaid benefits, you can contact Wisconsin Medicaid. Here are two ways to get information directly from Wisconsin Medicaid:

- You can call 800-362-3002 during regular business hours. TTY users call 888-701-1251.
- You can visit the Wisconsin Medicaid website (dhs.wisconsin.gov/medicaid).

CHAPTER 10: Ending membership in our plan

SECTION 1 Ending your membership in our plan

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

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- Call your State Medicaid Office at 1-800-362-3002 to learn about your Medicaid plan options.
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- **Your membership will usually end on the first day of the month after we get your request to change your plans.** Your enrollment in your new plan will also begin on this day.

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

You can end your membership during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without drug coverage.
 - Original Medicare *with* a separate Medicare drug plan.
 - Original Medicare *without* a separate Medicare drug plan.
 - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period is** from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **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 drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

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

- Usually, when you move
- If you have Wisconsin Medicaid.
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

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

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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

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

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- Call our member experience team at 855-653-4363 (TTY users call 711)
- Find the information in the *Medicare & You 2026* handbook
- Call Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	<ul style="list-style-type: none">• Enroll in the new Medicare health plan.• You'll automatically be disenrolled from Network Health Cares when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan	<ul style="list-style-type: none">• Enroll in the new Medicare drug plan.• You'll automatically be disenrolled from Network Health Cares when your new drug plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan	<ul style="list-style-type: none">• Send us a written request to disenroll. Call our member experience team at 855-653-4363 (TTY users call 711) if you need more information on how to do this.• You can also call Medicare, at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.• You'll be disenrolled from Network Health Cares when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without credible drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Wisconsin Medicaid benefits, call Wisconsin Medicaid at 800-362-3002, Monday – Friday from 7 a.m. to 6 p.m. (TTY at 888-701-1251). Ask how joining another plan or returning to Original Medicare affects how you get your Wisconsin Medicaid coverage.

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

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

- **Continue to use our in-network providers to get medical care.**
- **Continue to use our in-network pharmacies or mail-order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Network Health Cares must end your membership in certain situations

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

- If you no longer have Medicare Part A and Part B
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Wisconsin Medicaid. We review each member's Wisconsin Medicaid eligibility monthly. If we discover that you're no longer eligible for Wisconsin Medicaid, you will receive a call from us to discuss your eligibility. You will also receive a letter indicating that you may need to change insurance plans as you're no longer eligible for Network Health Cares (PPO D-SNP) due to loss of Wisconsin Medicaid. The letter will indicate the date by which you will either have to regain your Wisconsin Medicaid status to remain in Network Health Cares (PPO D-SNP) or you will need to enroll in another insurance plan. If you're within our plan's 3-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered benefits. However, during this period, we won't continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period.
- If you move out of our service area.
- If you're away from our service area for more than six months
 - If you move or take a long trip, call our member experience team at 855-653-4363 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your member ID card to get medical care. (We 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 have questions or want more information on when we can end your membership call our member experience team at 855-653-4363 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Network Health Cares isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, call our member experience team at 855-653-4363 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, our member experience team can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

SECTION 4 Third Party Liabilities

As a member of Network Health Cares (PPO D-SNP), 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

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costs that Network Health Insurance Corporation pays or arranges to pay on your behalf. Network Health Insurance Corporation has the right of subrogation against third parties liable or responsible for medical, surgical or hospital care costs that Network Health Insurance Corporation arranges or pays on your behalf.

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

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

As a member of Network Health Cares (PPO D-SNP), 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 12: Definitions

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

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

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

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

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to “**Original Biological Product**” and “**Biosimilar**”).

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (Go to “**Interchangeable Biosimilar**”).

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20 percent) as your share of the cost for services or prescription drugs after you pay any deductibles.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the

customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

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 drug. A copayment is a set amount (for example \$10), rather than a percentage.

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

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

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

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

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

Daily Cost-Sharing Rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment

for a one-month supply of a drug is \$30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person's eligibility.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception). You may also ask for an exception if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

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

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

Hospital Inpatient Stay – A hospital stay when you 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.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than five percent of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 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 Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases your prescriptions are covered only if they're 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. In-network providers may also be referred to as **plan providers**.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (Formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the Federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs don’t count toward the maximum out-of-pocket amount. (**Note:** Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that’s either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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 and in accord with generally accepted standards of the medical community
- c) Are provided in the least intense, most cost-effective setting or manner needed for your bodily injury or illness.

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

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

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

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

Medicare Drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part 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 our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medication Therapy Management (MTM) program - A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

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

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

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

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like 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.

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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. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan 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.

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

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through our plan.

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from in-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 in-network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

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

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

Prior Authorization – Approval in advance to get services or certain drugs based on specific criteria. Some in-network medical services are covered only if your doctor or other in-network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Some Part B and Part D drugs are covered only if your doctor or other in-network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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

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.

Quantity Limits – A management tool that’s designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real-Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

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

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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

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

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

Special Enrollment Period – A set time when members can change their health or drug plan or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you

Chapter 12 Definitions

move outside the service area, if you're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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

Step Therapy – A utilization tool that requires you to first try another Part B drug to treat your medical condition before we'll cover the 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 aren't the same as Social Security benefits.

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

Network Health Cares Member Experience Team

Method	Member Experience Team – Contact Information
CALL	855-653-4363 Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m. Our member experience team also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday – Friday from 8 a.m. to 8 p.m.
FAX	920-720-1908
WRITE	Network Health Medicare Advantage Plans PO Box 120 1570 Midway Place Menasha, WI 54952
WEBSITE	networkhealth.com

Wisconsin SHIP

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

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

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

Discrimination is Against the Law

Network Health complies with applicable Federal civil rights laws and doesn't discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Network Health doesn't exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Network Health's Compliance Officer.

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Network Health
Attn: Compliance Officer
1570 Midway Place
Menasha, WI 54952
Phone: 855-653-4363
(TTY users should call 711)
Email: compliance@networkhealth.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Network Health's website:
networkhealth.com.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-653-4363 (TTY: 711) or speak to your provider.

Albanian: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 855-653-4363 (TTY: 711) ose bisedoni me ofruesin tuaj të shërbimit.

Arabic: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات تنبيه: كما تتوفر وسائل مساعدة وخدمات مناسبة المساعدة اللغوية المجانية. اتصل على لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. أو تحدث إلى مقدم الخدمة. (711) 855-653-4363 الرقم

Chinese: 如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-653-4363（文本电话：711）或咨询您的服务提供商。

French: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-653-4363 (TTY : 711) ou parlez à votre fournisseur.

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-653-4363 (TTY : 711) an oder sprechen Sie mit Ihrem Provider.

Hindi: यदि आप हर्दी बोलते हैं, तो आपके लर्ए नःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लर्ए उपयुक्त सहायक साधन और सेवाएँ भी नःशुल्क उपलब्ध 855-653-4363 (TTY : 711) पर कॉल करें या अपने प्रदाता से बात करें।

Hmong: Yog hais tias koj hais Lus Hmoob muaj cov kev pab cuam txhais lus pub dawb rau koj. Cov kev pab thiab cov kev pab cuam ntxiv uas tsim nyog txhawm rau muab lus qhia paub ua cov hom ntaub ntawv uas tuaj yeem nkag cuag tau rau los kuj yeej tseem muaj pab dawb tsis xam tus nqi dab tsi ib yam nkaus. Hu rau 855-653-4363 (TTY : 711) los sis sib tham nrog koj tus kws muab kev saib xyuas kho mob.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-653-4363 (TTY : 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

Laotian: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 855-653-4363 (TTY : 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

Pennsylvania Dutch: Wann du Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 855-653-4363 (TTY: 711) uff odder schwetz mit dei Provider.

Polish: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-653-4363 (TTY : 711) lub porozmawiaj ze swoim dostawcą.

Russian: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-653-4363 (TTY : 711) или обратитесь к своему поставщику услуг.

Spanish: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-653-4363 (TTY : 711) o hable con su proveedor.

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-653-4363 (TTY : 711) o makipag-usap sa iyong provider.

Vietnamese: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-653-4363 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

5623-01-0625

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1570 Midway Pl.

Menasha, WI 54952

855-653-4363

TTY 711

Monday–Friday, 8 a.m. to 8 p.m.

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