Combined Evidence of Coverage and Disclosure Form (EOC/DF)

Effective January 1, 2024

Western Health Advantage MyCare Select

Health Maintenance Organization (HMO)
Medicare Advantage Plan

westernhealth ADVANTAGE

Contracted by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

January 1 – December 31, 2024

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of Western Health Advantage MyCare Select (HMO)

This document give you details about your Medicare health care and coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Services at 1.888.942.7377 for additional information. (TTY users should call 711). Hours are 7:00 a.m. to 8:00 p.m., seven days a week. This call is free.

This plan, Western Health Advantage MyCare Select (HMO), is offered by Western Health Advantage. (When this Evidence of Coverage says "we," "us" or "our," it means Western Health Advantage. When it says "plan" or "our plan," it means Western Health Advantage MyCare Select.)

This document is available for free in Spanish.

This information is available in a different format, including braille, large print, and audio.

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2025.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

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

There is no vested right to receive any particular benefit set forth in the plan. Plan benefits may be modified. Any modified benefit (such as the elimination of a particular benefit or an increase in the member's copayment) applies to services or supplies furnished on or after the effective date of the modification.

Evidence of Coverage Table of Contents

This list of chapters and page numbers is your starting point.

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Western Health Advantage MyCare Select, which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Western Health Advantage MyCare Select. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Western Health Advantage MyCare Select is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

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

Section 1.2 What is the Evidence of Coverage document about?

This *Evidence of Coverage* document tells you how to get your Medicare medical care covered through our plan. This document explains your rights and responsibilities, what is covered, and what you pay as a member of the plan and how to file a complaint if you are not satisfied with a decision or treatment.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of Western Health Advantage MyCare Select.

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

If you are confused, concerned, or just have a question, please contact our plan's Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in Western Health Advantage MyCare Select between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Western Health Advantage MyCare Select (HMO) after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Western Health Advantage MyCare Select each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- and – you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- and – you are a United States citizen or are lawfully present in the United States
- -- and – you meet the eligibility requirements established by the employer/union group sponsor's employment-based health coverage.

Section 2.2 Here is the plan service area for Western Health Advantage MyCare Select (HMO)

Our service area includes these counties in California: Marin, Napa, Sacramento, Solano, Sonoma and Yolo and portions of Colusa, El Dorado and Placer counties in Northern California.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this document). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health plan that is available in your new location.

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

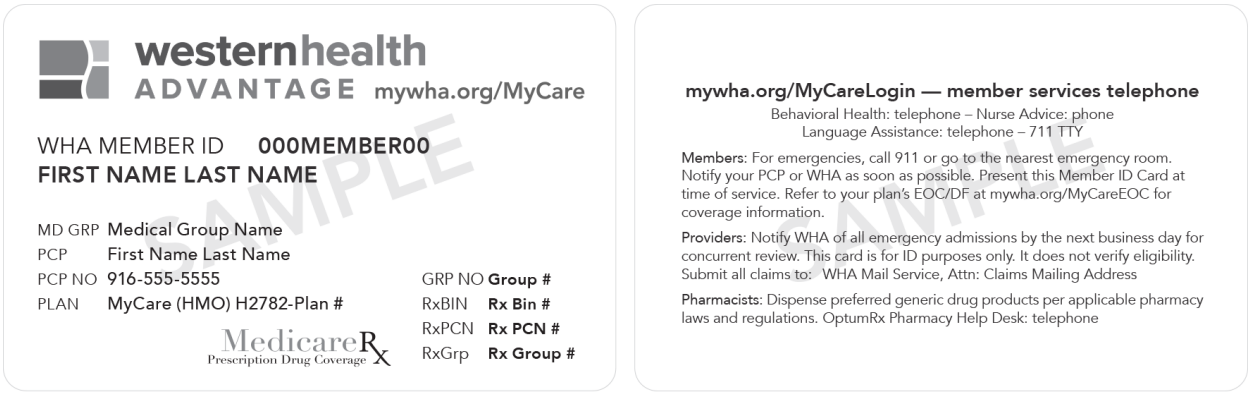
Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important materials you will receive

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card whenever you get any services covered by this plan. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Western Health Advantage MyCare Select membership 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.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

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

The *Provider Directory* lists our network providers.

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 any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers is available on our website at **mywha.org/MyCareDoctors**.

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. Your access to network specialists and hospitals is based upon your Primary Care Physician (PCP) selection. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this document). You may ask Member Services for more information about our network providers, including their qualifications. You can also view, download, or request a printed copy of the *Provider Directory* at **mywha.org/MyCareDoctors**. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for Western Health Advantage MyCare Select (HMO)

Section 4.1 Plan Premium

As a member of our plan, you pay a monthly plan premium. For 2024, the monthly premium for Western Health Advantage MyCare Select is $331.11. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2024* gives information about the Medicare premiums in the section called "2024 Medicare Costs." This explains how the Medicare Part B premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2024* from the Medicare website (**www.medicare.gov).** Or, you can order a printed copy by phone at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users call 1.877.486.2048.

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

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

SECTION 5 Keeping your plan membership record up to date

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

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

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

Let us know about these changes:

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

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this document).

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

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

Medicare requires that we collect information from you about any other medical insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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

SECTION 6 How other insurance works with our plan

Other Insurance

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

These rules apply for employer or union group health plan coverage in addition to this Western Health Advantage MyCare Select (HMO) plan:

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

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

Chapter 2. Important phone numbers and resources

SECTION 1 Western Health Advantage MyCare Select contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to Western Health Advantage MyCare Select Member Services. We will be happy to help you.

Method	Member Services Contact Information
CALL	Toll-Free: 1.888.942.7377 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
WRITE	Western Health Advantage Mail Service Attn: Member Services P.O. Box 14952, Salem, OR 97309
WEBSITE	**westernhealth.com/calpers/medicare**

Method	Coverage Decisions for Medical Care Contact Information
CALL	Toll-Free: 1.888.942.7377 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
TTY	711 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
WRITE	Western Health Advantage Mail Service Attn: Member Services P.O. Box 14952, Salem, OR 97309
WEBSITE	**westernhealth.com/calpers/medicare**

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

A "coverage decision" is a decision was made about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see **Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**.

Method	Appeals Contact Information
CALL	Toll-Free: 1.888.563.2250 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
TTY	711 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
FAX	916.563.2207
WRITE	Western Health Advantage Attn: Medicare Advantage Appeals and Grievances 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
WEBSITE	**westernhealth.com/calpers/medicare**

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see **Chapter 7 What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**.

Method	Complaints Contact Information
CALL	Toll-Free: 1.888.942.7377 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
TTY	711 Calls to this number are free. Hours are 7:00 a.m. to 8:00 p.m., seven days a week.
WRITE	Western Health Advantage Attn: Medicare Advantage Appeals and Grievances 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
WEBSITE	You can submit a complaint about Western Health Advantage MyCare Select directly to Medicare. To submit an online complaint to Medicare go to **www.medicare.gov/MedicareComplaintForm/home.aspx**.

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, see **Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*)**.

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

Method	Payment Requests Contact Information
WRITE	Western Health Advantage Mail Service Attn: Member Services P.O. Box 14952, Salem, OR 97309
WEBSITE	**westernhealth.com/calpers/medicare**

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

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

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

Method	Medicare Contact Information
CALL	1.800.MEDICARE, or 1.800.633.4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1.877.486.2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**www.medicare.gov** This is the official government website for Medicare. It gives you up- to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: Medicare Eligibility Tool: Provides Medicare eligibility status information. Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Western Health Advantage MyCare Select: Tell Medicare about your complaint: You can submit a complaint about Western Health Advantage MyCare Select directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, and review it with you. (You can call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

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

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

Method	To Access SHIP and Other Resources
VISIT	**www.medicare.gov** • Visit **www.shiphelp.org** (Click on SHIP LOCATOR in middle of page) • Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

Method	California Department of Aging Health Insurance Counseling and Advocacy Program (HICAP) Contact Information
CALL	1.800.434.0222
TTY	1.800.735.2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	California Department of Aging 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
WEBSITE	www.aging.ca.gov/Programs_and_Services/Medicare_Counseling

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For California, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta (California's Quality Improvement Organization)
CALL	1.877.588.1123 Local hours are 9 a.m. to 5 p.m. (Pacific Time) Monday through Friday and 11 a.m. to 3 p.m. (Pacific Time) on weekends and holidays. A message can also be left at the toll-free number 24 hours a day, seven days a week.
TTY	1.855.887.6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	**livantaqio.com**

SECTION 5 Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their 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, it is important that you contact Social Security to let them know.

Method	Social Security Contact Information
CALL	1.800.772.1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1.800.325.0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	**www.ssa.gov**

SECTION 6 Medi-Cal (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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

The programs offered through Medi-Cal help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- Qualifying Individual (QI): Helps pay Part B premiums.

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

To find out more about Medicaid and its programs, contact Medi-Cal.

Method	Medi Cal Eligibility Division (MCED) (California's Medicaid program) Contact Information
CALL	Toll Free 1.866.9881 916.552.9200 Automated service is available 24 hours a day/7 day a week. To speak to an agent, hours of operation Monday through Friday, 8 a.m. to 5 p.m., except for state holidays
WRITE	Medi-Cal Eligibility Division P.O. Box 997417 MS 4607, Sacramento, CA 95899-7417
WEBSITE	**www.dhcs.ca.gov/services/medi-cal**

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board Contact Information
CALL	1.877.772.5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1," you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	1.312.751.4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are not free.
WEBSITE	**www.rrb.gov**

SECTION 8 Do 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, you may call the employer/union benefits administrator or Member Services 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 Member Services are printed on the back cover of this document.) You may also call 1.800.MEDICARE (1.800.633.4227; TTY: 1.877.486.2048) with questions related to your Medicare coverage under this plan.

Chapter 3. Using the plan for your medical services

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

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

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

Section 1.1 What are "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.
- "Network providers" are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- "Covered services" include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare health plan, Western Health Advantage MyCare Select (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- The care you receive is included in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this document).
- The care you receive is considered medically necessary. "Medically necessary" means that the services, supplies, equipment or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You have a network primary care provider (a PCP) who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- You must receive your care from a network provider (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of- network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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

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

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

When you become a member of Western Health Advantage MyCare Select (HMO) you must choose a plan provider to be your PCP. Your PCP will coordinate the covered services you get as a plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist).

When you enroll in Western Health Advantage, you must select a Primary Care Physician (PCP) from one of Western Health Advantage's Medical Groups. Each new member should select a PCP close enough to his or her home to allow reasonable access to care. Your PCP is responsible for coordinating your health care by either direct treatment or referral to a participating specialist. All non-urgent care or non-emergency care should be received from your PCP or other Participating Provider as referred by your PCP.

You may choose any PCP within the Western Health Advantage network, as long as that PCP is accepting new patients. If we have not received a PCP selection from you, Western Health Advantage will assign a PCP to you.

The types of PCPs you can choose include:

- family practice physicians,
- internal medicine physicians*,
- general practice physicians, and
- obstetrician/gynecologists*.

*Note: Not all internal medicine physicians and obstetrician/gynecologists are designated PCPs. Some may practice only as specialist physicians. Visit **mywha.org/MyCareDoctors** to search for PCPs in your preferred specialty.

If you have never been seen by the PCP you choose, please call his/her office before designating him/her as your PCP. This gives the office the opportunity to explain patient requirements and answer any questions. The name of your PCP will appear on your Western Health Advantage identification card.

For information on how to select a PCP, and for a list of the participating PCPs, call Member Services or go to **mywha.org/MyCareDoctors** and search our online *Provider Directory*.

Note: Regardless of which Medical Group your PCP is affiliated with, you may be able to receive services from participating specialists in other Medical Groups / IPAs. See "Advantage Referral" Section 2.2 of this chapter for more information.

Your Medical Group may have referral rules to obtain some ancillary services, such as physical therapy or other services, from particular providers or facilities.

How do you choose your PCP?

You may search for a PCP in the *Provider Directory* or you may contact Member Services for assistance. Please contact Member Services to select a PCP at 888.942.7377 (TTY: 711) or by going to our website at **mywha.org/MyCareDoctors**. If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP. Regardless of which medical group your PCP is affiliated with, you may be able to receive services from participating specialists in other medical groups/IPAs. (An IPA is a business entity organized and owned by a network of independent physician practices. For this and other definitions, see Chapter 10.)

See "Advantage Referral" in Section 2.2 of this chapter for more information.

Since your PCP coordinates all your covered care, it is important that you are completely satisfied with your relationship with him or her. If you want to choose a different PCP, you can do so by calling the Member Services Department at 1.888.942.7377 before your scheduled appointment. Note: Members are responsible for submitting their own PCP change requests. The effective date is the first day of the month following notification. You must wait until the effective date before seeking care from your new PCP or the services may not be covered. You are still covered under your existing physician until the effective date of your new doctor.

Transferring to another Primary Care Provider or Medical Group

Any member may change PCPs or Medical Groups/IPAs as described in this Evidence of Coverage. You may transfer from one to another as follows:

- If your requested PCP is in the same Medical Group as your existing PCP, you may request to transfer to your new PCP effective the first of the following month.
- If your requested PCP is in a different Medical Group than your existing PCP, you may request to transfer to the new PCP effective the first of the following month unless you are confined to a hospital, in a surgery follow-up period and not yet released by the surgeon, or receiving treatment for an acute illness or injury and the treatment is not complete.

Except as described below, PCP changes are always effective the first of the month following the request, and may not be changed retroactively:

- If you were "auto-assigned" to a PCP and you notify Western Health Advantage within 45 days of your effective date that you wish to be assigned to a PCP with whom you have a current doctor-patient relationship, and you have not received any services from the auto-assigned Medical Group, you may request to be assigned to the new PCP retroactively to your effective date; or
- When deemed necessary by Western Health Advantage.

Section 2.2 What kinds of medical care can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x- rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible (e.g., when the enrollee is out of the service area). For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this document.)
- Chiropractic and acupuncture services.
- Annual vision exam.

Advantage Referral: In order to expand the choice of physician specialists for you, Western Health Advantage has a unique program called "Advantage Referral." The "Advantage Referral" program allows you to access some of the specialist physicians within your network (as listed in the *Provider Directory*), instead of limiting your access to those specialists who have a direct relationship with your PCP and medical group.

While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider.

Section 2.3 How to get care from specialists and other network providers

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

If medically appropriate, your PCP will provide a written **referral** to your selected participating specialist. Please remember that if you receive care from a participating specialist without first receiving a referral (or if you see a non-participating specialist without prior authorization) you may be liable for the cost of those services. You will receive a notification of the details of your referral to a participating specialist and the number of visits as ordered by your physician. You need to bring this referral form to your appointment. If you receive a same-day appointment, the specialist will receive verbal or fax authorization, which is sufficient along with your ID card.

OB/GYN services for women and annual eye exams are included in the Advantage Referral program and do not require a PCP referral or prior authorization, as long as the provider is listed in the Western Health Advantage *Provider Directory*.

If you have a certain life-threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV or AIDS, you may be allowed a standing referral. A standing referral is a referral for more than one visit, to a specialist or "specialty care center" that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires ongoing monitoring. Those specialists designated as having expertise in treating HIV or AIDS are designated with a ‡ in our *Provider Directory* under their licensed specialty.

Certain covered services require **prior authorization** by Western Health Advantage or its medical group in order to be covered. Your PCP must contact the participating medical group with which your PCP is affiliated or, in some cases, Western Health Advantage to request the service or supply be approved for coverage before it is rendered. If prior authorization is not obtained, you may be liable for the payment of services or supplies. Requests for prior authorization will be denied if the requested services are not medically necessary as determined by Western Health Advantage or the medical group, or are requested with a non-participating provider and a participating provider is available to supply medically necessary services for the member.

See Chapter 4, Section 2.1 for a list of services that require prior authorization.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. if your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

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

- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing. Prior authorization is needed.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.4 How to get care from out-of-network providers

Prior authorization is required for services from non-participating providers except in urgent care situations arising outside Western Health Advantage's service area or emergency situations. For example, a covered service may be medically necessary but not available from participating providers, or, a participating specialist, behavioral health provider or acupuncturist may not be geographically accessible to a member. Then, your physician must obtain prior authorization from Western Health Advantage or its delegated medical group before you receive services from a non-participating provider. See section 2.3 above on how to obtain a prior authorization.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- Get help as quickly as possible. Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- As soon as possible, make sure that our plan has been told about your emergency.

We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Contact Member Services at 916.942.7377 or 1.888.942.7377 between 7:00 a.m. to 8:00 p.m., seven days a week.

What is covered if you have 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.

Western Health Advantage covers you for urgent care and emergency care services wherever you are in the world. Please note that emergency room visits are not covered for non-emergency situations. See Chapter 10 "Definitions of important words" section of this document for explanation of urgent care and emergency care.

If emergency care is obtained from a non-participating provider, Western Health Advantage will reimburse the provider for covered medical services received for Emergency situations, less the applicable copayment.

If an urgent care situation arises while you are outside of Western Health Advantage's service area, Western Health Advantage will reimburse a non-participating provider for covered medical services to treat the urgent care situation, less the applicable copayment. If you have an urgent care situation in Western Health Advantage's service area, you must contact your PCP's office for direction about where to go for urgent care treatment within the contracted network.

If an emergency situation arises whether you are in Western Health Advantage's service area or outside of the service area, call "911" immediately or go directly to the nearest hospital emergency room. If an urgent care situation arises while you are in Western Health Advantage's service area, call your PCP. You can call your doctor at any time of the day, including evenings and weekends or call Western Health Advantage's nurse advice line (see phone number on the back of your WHA member ID card).

Explain your condition to your doctor, the Physician on call at your doctor's office, or the nurse on the nurse advice line and he/she will advise you. In the event you are not able to reach your physician or the nurse advice line , you may go to an urgent care facility affiliated with your Medical Group. For more information about the nurse advice line, please see "Health and wellness education programs" in the Medical Benefits Chart in Chapter 4, Section 2.1.

If you are hospitalized at a non-participating facility because of an emergency, Western Health Advantage must be notified within twenty-four (24) hours or as soon as possible. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a family member, friend, or hospital staff member. Western Health Advantage will work with the hospital and physicians coordinating your care, make appropriate payment provisions and, if possible, arrange for your transfer back to a participating hospital.

Post-Stabilization Care

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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

Follow-up care after an emergency room visit is not considered an emergency situation. If you receive emergency treatment from an emergency room physician or non-participating physician and you return to the emergency room or physician for follow-up care (for example, removal of stitches or redressing a wound), you will be responsible for the cost of the service. Call your PCP for all follow-up care. If your health problem requires a specialist, your PCP will refer you to an appropriate participating provider as needed. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, we will cover additional care

only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – or – The additional care you get is considered "urgently needed services" and you follow the rules for getting this urgently needed services (for more information about this, see Section 3.2 below).

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

What are "urgently needed services"?

An "urgently needed service" is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed services may be furnished by out-of-network providers when it is unreasonable, given your circumstances to obtain immediate care from network providers.

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

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

If an urgent care situation arises while you are outside of Western Health Advantage's service area, Western Health Advantage will reimburse a non-participating provider for covered medical services to treat the urgent care situation, less the applicable copayment. If you have an urgent care situation in Western Health Advantage's service area, you must contact your PCP's office for direction about where to go for urgent care treatment within the contracted network.

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

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- Western Health Advantage covers you for urgent care and emergency care services wherever you are in the world. Please note that emergency room visits are not covered for non-emergency situations.
- Western Health Advantage will reimburse the provider for covered medical services received for emergency situations, less the applicable copayment.
- If an urgent care situation arises while you are outside of Western Health Advantage's service area, Western Health Advantage will reimburse for covered medical services to treat the urgent care situation, less the applicable copayment. For additional information, see the "Worldwide emergency and urgent care" section of the medical benefits chart in Chapter 4 below.

Section 3.3 Getting care during a disaster

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

Please visit the following website: **mywha.org/MyCareDisasterCare** for information on how to obtain needed care during a disaster.

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

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

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

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

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

Western Health Advantage MyCare Select covers all medically necessary, services listed in the Medical Benefits Chart in Chapter 4 of this document). If you receive services not covered by our plan, or services obtained out-of-network and were not authorized you are responsible for paying the full cost of the services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Paying for costs once a benefit limit has been reached will not count toward an out-of-pocket maximum.

SECTION 5 How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are 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 will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

Although you do not need to get our plan's permission to be in a clinical research study, we encourage **you to notify us in advance when you choose to participate in a Medicare-qualified clinical trial.**

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

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

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

After Medicare has paid 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 will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial services and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication *Medicare and Clinical Research Studies.* (The publication is available at: **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**.)

You can also call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

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

Section 6.1 What is a religious non-medical health care institution?

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

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

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

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

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

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

You are covered for up to 90 days per benefit period for inpatient hospital stays. Please refer to the Medical Benefits Chart located in Chapter 4, Section 2.

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Western Health Advantage MyCare Select, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services for more information.

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

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

The payments you made while enrolled in your plan do not count

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 do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (where to our plan or to Original Medicare) do not count.

SECTION 7.2 Rules for Oxygen Equipment, Supplies, and Maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Western Health Advantage MyCare Select (HMO) 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 Western Health Advantage MyCare Select or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your 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. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you 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 is covered and what you pay)

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Western Health Advantage MyCare Select (HMO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

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

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in-network medical services that are covered by our plan This limit is called the maximum out-of-pocket amount for medical services. For calendar year 2024 this amount is $1,500 for in-network care.

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your maximum out-of-pocket amount.) If you reach the maximum out-of-pocket amount of $1,500, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of Western Health Advantage MyCare Select, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Provider may not add additional separate charges, called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the 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 receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies of urgently needed services.)
- If you believe a provider has "balance billed" you, call Member Services.

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

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

The Medical Benefits Chart on the following pages lists the services Western Health Advantage MyCare Select (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.

- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral."
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk. In addition, the following services not listed in the Benefits Chart require prior authorization:
- Services from non-participating providers except in urgent care situations arising outside Western Health Advantage's service area or emergency situations. For example, a covered service may be medically necessary but not available from participating providers, or a participating specialist, behavioral health provider, acupuncturist or chiropractor may not be geographically accessible to a member. Then, your physician must obtain prior authorization from Western Health Advantage or its delegated Medical Group before you receive services from a non-participating provider;
- Care with a specialist physician that extends beyond an initial number of visits or treatments;
- Physical therapy, speech therapy and occupational therapy;
- Rehabilitative services (cardiac, respiratory, pulmonary);
- All hospitalizations;
- Transplants and related travel expenses;
- All surgeries;
- Experimental medical and surgical procedures, equipment and medications;
- Non-emergent medical transport or ambulance care;
- Second medical opinions;
- Replacement lenses or frames for lenses or frames that are lost, stolen or broken, unless benefits are otherwise available;
- Scheduled tests and procedures;
- Other services if your Medical Group requires prior authorization (ask your PCP); and
- Inpatient and non-routine outpatient behavioral health services, including outpatient electroconvulsive therapy, intensive outpatient program, partial hospitalization program, psychological testing, repetitive transcranial magnetic stimulation, applied behavioral analysis and office-based opioid treatment.
- We may also charge you "administrative fees" for missed appointments or for not paying your required cost sharing at the time of service. Call Member Services if you have questions regarding these administrative fees.)

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* Handbook. View it online at **www.medicare.gov** or ask for a copy by calling 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

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

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain (Medicare covered) Covered services include: • Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: o For the purpose of this benefit, chronic low back pain is defined as: ▪ Lasting 12 weeks or longer; ▪ nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); ▪ not associated with surgery; ▪ and not associate with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Acupuncture services provided through Landmark Healthplan of California, Inc. **lhp-ca.com** 800.298.4875	$10 copay for each Medicare-covered visit.
Acupuncture (Supplemental) Routine acupuncture services are covered when they are: • Received from a qualified licensed network acupuncturist who is practicing within the scope of their license. • Treatment of pain related to acute neuromusculoskeletal conditions. • Not listed as an exclusion. No PCP referral is required. Acupuncture services provided through Landmark Healthplan of California, Inc. **lhp-ca.com** 800.298.4875	$15 copay for each routine acupuncture visit. Plan covers up to 20 visits per year for routine chiropractic and acupuncture services combined.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Ambulance services* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. *Prior authorization rules may apply for non-emergent transportation services, including out-of-network to in-network facilities.	$0 copay for each Medicare-covered ground or air transportation service.
Annual physical exam Our plan covers an annual routine physical exam in addition to the Medicare-covered annual wellness visit. This exam is covered once per calendar year. This exam allows you to see your provider annually without a specific medical complaint and includes a comprehensive physical exam. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for one routine physical exam every year.
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. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Assist America U.S. Emergency Travel Logistics Anytime you travel 100 miles or more away from home, even in a foreign country, you are eligible for Assist America's assistance services, such as medical consultation and referrals, prescription assistance, lost luggage or document assistance, and other vital services in the event you face a medical or nonmedical emergency. Learn more about Assist America by calling 1.800.872.1414 or visit **assistamerica.com**. Please Note: Assist America is not a medical or travel insurance. You or your health plan are responsible for medical bills incurred while you are traveling. All arrangements must be through Assist America. Coverage applies if members are at least 100 miles from permanent residence for no longer than 90 consecutive days. There is no plan coverage days 91 and beyond.	$0 copay for U.S. Emergency Travel Logistics services through Assist America.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition. This service may require prior authorization and/or referral.	There is no coinsurance, copayment, or deductible 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 Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for covered screening mammograms.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered cardiac rehab service. $0 copay for each Medicare-covered intensive cardiac rehab service.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Chiropractic services (Medicare covered) Covered services include: • Manual manipulation of the spine to correct subluxation No PCP referral is required. Chiropractic services, provided through Landmark Healthplan of California, Inc. **lhp-ca.com** 800.298.4875	$10 copay for each Medicare-covered chiropractic visit.
Chiropractic services (Supplemental) Non-Medicare-covered routine chiropractic services Routine chiropractic services are covered when they are: • Received from a qualified licensed network chiropractor who is practicing within the scope of their license • Treatment of pain related to acute neuromusculoskeletal conditions • Not listed as an exclusion No PCP referral is required. Chiropractic services, provided through Landmark Healthplan of California, Inc. **lhp-ca.com** 800.298.4875	$15 copay for each routine chiropractic visit. Plan covers up to 20 visits per year for routine chiropractic and acupuncture services combined.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years. For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. $0 copay for each Medicare-covered screening barium enema.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: Medicare-covered dental services including the following: • 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 for neoplastic disease, or services that would be covered when provided by a medical doctor. *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered dental service.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: o Blood glucose monitor and/or insulin pump o 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: o One pair per calendar year of therapeutic custom molded shoes (including inserts provided with such shoes) o 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) o Coverage includes fitting • Diabetes self-management training is covered under certain conditions Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition. *This service may require prior authorization and/or referral.	$0 copay Medicare-covered blood glucose monitor or insulin pump. $0 copay for Medicare covered diabetic monitoring supplies. $0 copay for Medicare covered Diabetic therapeutic shoes or inserts.* $0 copay for Medicare covered diabetes self-management training services.
Durable medical equipment (DME) and related supplies* (For a definition of "durable medical equipment," see Chapter 10 of this document as well as Chapter 3, Section 7.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **mywha.org/MyCareLogin**. *This service may require prior authorization and/or referral.	$0 copay for Medicare-covered durable medical equipment.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are 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 is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Includes worldwide coverage for services needed to evaluate or stabilize an emergency medical condition. Please see the "Worldwide emergency and urgent care" section of this medical benefits chart.	$50 copay for each Medicare-covered emergency room visit (copay waived if admitted to hospital within 24 hours). $0 copay for U.S. Emergency Travel Logistics services through Assist America. For benefit information, see the "Assist America U.S. Emergency Travel Logistics" section of this chart. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. See the "Inpatient hospital services" section of this medical benefits chart for inpatient cost-sharing information.
Health and wellness education programs: Nurse Advice When you need medical advice about a health issue, Western Health Advantage has nurses available 24/7 to answer questions and address any concerns. Through our confidential nurse advice line, members may talk with a registered nurse who can: evaluate symptoms, offer advice, help in getting care and treatment options, and determine whether urgent or emergency care from a nearby network facility is needed. Our nurse advice is available by phone (refer to your WHA ID card back for number) or through "live chat" and "email messaging," which can be accessed at **mywha.org/MyCareNurse**.	$0 copay for nurse advice line services.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Health and wellness education programs: Silver&Fit® **Silver&Fit®** is a fitness and healthy aging program designed to help you achieve better health through regular physical activity. The following are available at no cost to you: • Workout Plans: By answering a few online questions about your areas of interest, you will receive a customized workout plan, including instructions on how to get started and suggested digital workout videos. • Digital Workouts: You can view on-demand videos through the website's and mobile app's digital workout library, including Silver&Fit Signature Series Classes®. • Fitness Center Membership: You can visit participating fitness centers or YMCAs near you that takes part in the program.* You also have access to the Premium Fitness Network, which includes additional fitness center and studio choices and unique experiences like swimming centers, rock climbing gyms, and rowing centers, each with a buy-up price • Home Fitness Kits: You are eligible to receive one Home Fitness Kit per benefit year from a variety of fitness categories. • Well-Being Club: By setting your preferences for well-being topics on the website, you will see resources tailored to your interests and healthy habit goals including articles, videos, live-streaming classes, and meetups**. • Healthy Aging Coaching: You can participate in sessions by telephone with a trained coach where you can discuss topics like exercise, nutrition, social isolation, and brain health. • Silver&Fit Connected!™: The Silver&Fit Connected! tool will assist with tracking your activity. To sign up or to learn more, visit **silverandfit.com** or call Silver&Fit at 1.877.427.4788 (TTY/TDD 711), Monday to Friday 5 a.m. to 6 p.m. *Non-standard membership services that call for an added fee are not part of the Silver&Fit program and will not be reimbursed. **ASH Fitness has no affiliations, interest, endorsements, or sponsorships with any of the organizations or clubs. Some clubs may require a fee to join. Such fees are not part of the Silver&Fit programs and will not be reimbursed by ASH Fitness. (continued to next page)	$0 copay for the Silver&Fit program.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Health and wellness education programs: Silver&Fit® (continued) The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, Silver&Fit Connected!, and Something for Everyone are trademarks of ASH. Limitations, member fees, and restrictions may apply. Participating facilities and fitness chains may vary by location and are subject to change. Kits and rewards are subject to change.	(see previous page)
Hearing Exam One (1) routine hearing exam per year.	$0 copay for each Medicare-covered exam to diagnose and treat hearing and balance issues.
Hearing Aids Up to $1,000 toward the cost of 2 non-implantable hearing aids from the applicable TruHearing catalog every 3 years (limit 1 hearing aid per ear). Allowance may be applied to cost of hearing aids and earmolds. After plan-paid benefit, you are responsible for the remaining costs. * You must see a TruHearing provider to use this benefit. Call 855.635.5576 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: • Hearing aid accessories • Additional provider visits • Additional batteries • Hearing aids that are not in the applicable catalog • Costs associated with loss and damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan.	Any amount in excess of your allowance.* Costs you pay for hearing services, including hearing exam copayments and hearing aid costs, will not count toward your out-of-pocket maximum.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *This service may require prior authorization and/or referral.	$0 copay for Medicare covered home health services.

MEDICAL BENEFITS CHART	What you must pay when
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier *This service may require prior authorization and/or referral.	$0 copay for Medicare other Part B drugs. $0 copay for each Medicare-covered home health visit. $0 copay for non- Medicare-covered health education services. $0 copay for Medicare-covered durable medical equipment.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice, you have the right to remain in your plan, if you chose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rule (such as if there is a requirement to obtain prior authorization: • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare). (continued to next page)	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. You must get care from a Medicare-certified hospice provider. $0 copay for hospice consultation services obtained in a primary care physician's office or $0 copay for hospice consultation services obtained in a specialist's office. An additional cost-sharing may apply for hospice consultation services provided during an inpatient hospital stay. You may have a cost sharing for drugs and respite care.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Hospice care (continued) For services that are covered by our plan but are not covered by Medicare Part A or B: • Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. Please Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	(see previous page)
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. $0 copayment for all other Medicare-covered Part B immunizations.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Except in an emergency, your provider must tell us that you are going to be admitted to the hospital. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • 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 (continued on next page)	$0 copay per day. Please Note: If you receive items unrelated to the condition you are being treated for or take-home supplies, you may be responsible for payment of these items. If you get authorized inpatient care at an out-of- network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Inpatient hospital care* (continued) • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan 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. Travel expenses are subject to prior authorization and eligibility of the recipient. The total maximum reimbursement allowed for transplant travel is $5,000. Food and lodging expenses are limited to up to $150 per day and apply to the $5,000 maximum. • Blood – including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood used. • Physician services Please Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at by calling 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week. *This service may require prior authorization and/or referral.	(see previous page)

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or a psychiatric unit of a general hospital. Except in an emergency, your provider must tell us that you are going to be admitted to the hospital. WHA has contracted with United Behavioral Health, an affiliate of Optum, to manage your mental health and alcohol and drug abuse benefits. If you need behavioral health treatment or have questions about your behavioral health benefits, please call United Behavioral Health at1.855.857.9748. United Behavioral Health must provide any authorizations required for mental health services. *This service may require prior authorization and/or referral.	$0 copay per admission for Medicare-covered hospital stay. No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, 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 *This service may require prior authorization and/or referral.	The services listed to the left will continue to be covered at the cost-sharing amounts shown in this medical benefits chart for that specific service. For example, physical therapy would be covered at the cost-sharing amount listed in the "Outpatient rehabilitation services." For Medicare-covered medical supplies, including casts and splints, you typically pay the applicable cost-sharing.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Meal Benefit Immediately following discharge from an inpatient stay at a hospital, skilled nursing facility or rehabilitation facility, 2 meals per day for 4 weeks. Total maximum of 56 meals after each discharge for up to 4 times per year.	$0 copay
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to postmenopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases *This service may require prior authorization and/or referral.	There is no coinsurance, copay, or deductible for Medicare Part B chemotherapy drugs and other Part B drugs.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Opioid treatment program services* Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing *Prior authorization is required for Specialist services. No prior authorization required for PCP services.	$0 copay for each Medicare-covered opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician • Materials and supplies • Special imaging procedures such as MRI, CT, and PET scans • Special diagnostic tests, such as ultrasounds and Holter Monitoring • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory test • Blood – including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood used. • Other outpatient diagnostic tests and procedures Please Note: If you receive services in addition to the Medicare covered lab, blood, or other diagnostic tests/procedures, a separate cost-sharing for that service may apply. *This service may require prior authorization and/or referral.	$0 copay for Medicare covered x-rays. $0 copay for Medicare covered therapeutic radiology services and supplies. $0 copay for Medicare covered therapeutic and diagnostic radiology services and supplies (such as MRI's and CT scans). 0% for Medicare-covered surgical supplies and devices to reduce fractures and dislocations. $0 copay for Medicare covered lab services. $0 copay for Medicare covered blood services. $0 copay for Medicare covered outpatient diagnostic tests and procedures.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. Please Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week. *This service may require prior authorization and/or referral.	$0 copay for Medicare covered observation services.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Outpatient hospital services* We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it. If you need behavioral health treatment or have questions about your behavioral health benefits, please call United Behavioral Health at 1.855.857.9748. • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself Please Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf** or by calling 1.800.MEDICARE (1.800.633.4227). TTY users call 1.877.486.2048. You can call these numbers for free, 24 hours a day, 7 days a week. *This service may require prior authorization and/or referral.	$50 copay for Medicare-covered emergency room visit (copay waived if admitted to hospital within 24 hours). $0 copay for each Medicare covered outpatient or hospital surgical service. $0 copay for each Medicare-covered ambulatory surgical center service. There is no facility fee for outpatient clinic visits. $0 copay for Medicare covered lab services and blood services. $0 copay for other diagnostic tests and procedures. $0 copay for Medicare covered partial hospitalization program services. $0 copay for Medicare covered x-rays. $0 copay for Medicare covered therapeutic radiology services and supplies. $0 copay for Medicare covered special imaging procedures and special diagnostic tests. 0% for Medicare covered medical supplies or casts. 0% for Medicare-covered Part B chemotherapy drugs and other Part B drugs. Please Note: If you receive items unrelated to the condition you are being treated for or take-home supplies, you may be responsible for payment of these items.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Outpatient mental health care* Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. This care includes medically necessary clinical laboratory tests ordered by a participating psychiatrist or attending physician. Office visits include, but are not limited to: • Mental health individual and group evaluation and therapy, psychological testing*, and repetitive transcranial magnetic stimulation*. Other outpatient services include intensive outpatient program*, partial hospitalization/day treatment*, outpatient electroconvulsive therapy* and non-emergency psychiatric transportation*. WHA has contracted with United Behavioral Health, an affiliate of Optum, to manage your mental health and alcohol and drug abuse benefits. If you need behavioral health treatment or have questions about your behavioral health benefits, please call United Behavioral Health at 1.855.857.9748. Untied Behavioral Health must provide any authorizations required for mental health services. *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered individual or group therapy visit. $0 copay for each Medicare-covered partial hospitalization service.
Outpatient rehabilitation services* Covered services include: Physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered occupational therapy visit. $0 copay for each Medicare-covered physical and/or speech therapy visit

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services* Outpatient services for evaluation and care for alcoholism and chemical dependency are covered and include detoxification services, and must be provided by a Participating Provider. Office visits include, but are not limited to, psychological testing*, substance abuse disorder individual and group counseling, medical treatment for withdrawal symptoms, office based opioid treatment*, substance abuse disorder methadone maintenance treatment*, and substance abuse disorder outpatient detoxification. Outpatient other services include intensive outpatient program* and partial hospitalization/day treatment*. WHA has contracted with United Behavioral Health, an affiliate of Optum, to manage your mental health and alcohol and drug abuse benefits. If you need behavioral health treatment or have questions about your behavioral health benefits, please call United Behavioral Health at 1.855.857.9748. United Behavioral Health must provide any authorizations required for mental health services. *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered individual or group therapy visit. $0 copay for each Medicare-covered partial hospitalization service. $0 copay for each Medicare-covered office based opioid treatment.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Please Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." *This service may require prior authorization and/or referral.	$0 copay for Medicare covered services at an ambulatory surgical center. $0 copay for Medicare covered surgical services at outpatient hospital facility.
Over-the-counter items (OTC) **Optum® Personal Care Benefits** gives you a quarterly allowance to purchase over-the-counter medications, vitamins, bandages and much more with no shipping cost to you. You can purchase health and wellness products from a catalog via phone, web or mail. Products may not be purchased at a local retail pharmacy or through any source other than OTC benefit channels. OTC items are available through home delivery only. Your OTC unused allowance expires at the end of each quarter and does not rollover to the next quarter. For assistance, contact Optum Personal Care Benefits Customer Service at 1.866.582.1043.	$0 copay for OTC items. Plan covers up to $100 every three months. Unused portions do not carry over to the next quarter.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and Intensive outpatient services* "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. **Please Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. WHA has contracted with United Behavioral Health, an affiliate of Optum, to manage your mental health and alcohol and drug abuse benefits. If you need behavioral health treatment or have questions about your behavioral health benefits, please call United Behavioral Health at 1.855.857.9748. United Behavioral Health must provide any authorizations required for mental health services. *This service may require prior authorization and/or referral.	$0 copay per day for Medicare covered partial hospitalization services.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits* Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: urgent care, PCP and specialist services, and outpatient mental health services o 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 a network provider who offers the service by telehealth. o Services will be provided via interactive audio and video communication when deemed clinically appropriate by the network provider rendering the service. • 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 • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services o Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers (continued on next page)	$0 copay for each Medicare-covered primary care provider (PCP) visit. $0 copay for each Medicare-covered outpatient or hospital surgical service. $0 copay for each Medicare-covered ambulatory surgical service. $0 copay for each Medicare-covered specialist visit. Referral required for hearing and balance exam cost-share, please see the "Hearing services" section of this medical benefit chart. $0 copay for Medicare-covered telehealth service.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits* (continued) • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: o You're not a new patient **and** o The evaluation doesn't lead to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours of the soonest available appointment (continued on next page) • Consultation your doctor has with other doctors by phone, internet, or electronic health record if you're not a new patient • Second opinion by another network provider 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) *This service may require prior authorization and/or referral.	(see previous page)
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) Routine foot care for members with certain medical conditions affecting the lower limbs *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered podiatry visit. $0 copay for each Medicare-covered outpatient or hospital surgical service. $0 copay for each Medicare-covered ambulatory surgical service.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for an annual Medicare-covered digital rectal exam.
Prosthetic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. *This service may require prior authorization and/or referral.	0% Medicare-covered prosthetic devices. 0% for related Medicare covered supplies.
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Pulmonary rehabilitation visits are limited to 36 sessions over a 36-week period with an option for an additional 36 sessions if medically necessary. *This service may require prior authorization and/or referral.	$0 copay for each Medicare-covered pulmonary rehab service.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 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. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible members are: people aged 50 – 77 years 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 receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease* Covered services include: Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs." *This service may require prior authorization and/or referral.	$0 copay for Medicare covered kidney disease education services. 0% for Medicare-covered dialysis services. There is no additional charge for dialysis treatments received during a Medicare-covered inpatient hospital stay. Please refer to the "Inpatient hospital care" section of this medical benefits chart for inpatient hospital stay cost-sharing amounts. 0% for Medicare-covered home dialysis equipment and supplies. $0 copay for each Medicare-covered home health visit.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing facility care," see Chapter 10 of this document. Skilled nursing facilities are sometimes called "SNFs.") You are covered for up to 100 days per benefit period for Medicare covered SNF stays. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital *This service may require prior authorization and/or referral.	$0 copay per day for days 1-100 Medicare covered SNF care. The benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital after one benefit period has ended, a new one will begin. All inpatient stays, regardless of condition, will apply towards the benefit period. Your SNF benefits are based on the calendar date. If you are admitted into the facility in 2024 and are not discharged until 2025, your copayment amount per day may be different.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: • We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco related disease or are taking medicine that may be affected by tobacco: • We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. *This service may require prior authorization and/or referral.	$0 copay for each Medicare covered SET visit.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider then your plan will cover the urgently needed services from a provider out-of-network. Please see the "Worldwide emergency/urgent care" section of this medical benefits chart.	$0 copay for each Medicare-covered visit. If you are admitted to the hospital within 24 hours of your urgent care visit for the same condition, you do not have to pay the urgent care visit copay.
Vision care (Medical services) Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year Vision hardware • Post-cataract: Your plan covers one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Medical vision hardware: Medical vision hardware is included under the "Prosthetic devices and related supplies" section of this medical benefits chart.	$0 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. $0 copay for an annual Medicare-covered preventive glaucoma screening. $0 copay for one diabetic retinopathy screening exam per calendar year. $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery. 0% for Medicare-covered prosthetic devices and related supplies.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Vision care (Routine non-Medicare-covered) Covered services include: • Routine eye exam – one visit per year with a participating provider for a routine eye exam, to include a refraction • Routine eye wear – routine contact lenses or hardware allowance (to include eyeglass lenses and frames) No PCP Referral required; routine eye exam provided by an EyeMed participating provider. Eye wear coverage provided by EyeMed. eyemed.com 844.844.0892.	$0 copay for 1 routine vision exam, including refraction, every year. Plan will pay up to $200 for routine eye wear (contact lenses, eyeglass frames and/or eyeglass lenses) every two years. *The amount you pay for these services does not count toward your maximum out-of-pocket.
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. Important: We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit. Please Note: if you are treated or monitored for an existing medical condition during the visit when you receive this preventive service, a copay or coinsurance may apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

MEDICAL BENEFITS CHART Services that are covered for you	What you must pay when you get these services
Worldwide emergency and urgent care Western Health Advantage covers you for urgent care and emergency care services wherever you are in the world. Please note that emergency room visits are not covered for nonemergency situations. If emergency care is obtained from a non-participating provider, Western Health Advantage will reimburse the provider for covered medical services received for emergency situations, less the applicable copayment. If an urgent care situation arises while you are outside of Western Health Advantage's service area, Western Health Advantage will reimburse for covered medical services to treat the urgent care situation, less the applicable copayment. If you have an urgent care situation in Western Health Advantage's service area, you must contact your PCP's office for direction about where to go for urgent care treatment within the contracted network. If an **emergency** situation arises whether you are in Western Health Advantage's service area or outside of the service area, call "911" immediately or go directly to the nearest hospital emergency room. • If an **urgent care** situation arises while you are in Western Health Advantage's service area, call your PCP. You can call your doctor at any time of the day, including evenings and weekends or call Western Health Advantage's nurse advice line using the phone number on the back of your WHA member ID card. Explain your condition to your doctor, the physician on call at your doctor's office, or the nurse on the nurse advice line and he/she will advise you. In the event you are not able to reach your physician or the nurse advice line, you may go to an urgent care facility affiliated with your medical group. For more information about the nurse advice line, please see section titled "Health and wellness education programs." If you are hospitalized at a non-participating facility because of an emergency, Western Health Advantage must be notified within twenty-four (24) hours or as soon as possible. This telephone call is extremely important. If you are unable to make the call, have someone else make it for you, such as a family member, friend, or hospital staff member. Western Health Advantage will work with the hospital and physicians coordinating your care, make appropriate payment provisions and, if possible, arrange for your transfer back to a participating hospital.	$50 copay for each worldwide emergency care visit. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. $0 copay for each worldwide urgent care visit. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. $50 copay for emergency care. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. $0 copay for urgently needed services. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. $0 copay per admission for emergency inpatient care

SECTION 3 What services are not covered by the plan?

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

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan.

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

If you get services that are excluded (not covered), you must pay for them yourself. except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. 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 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
All costs associated with surrogate parenting. This includes, but is not limited to, embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a surrogate arrangement. A surrogate pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the surrogate is a member of Western Health Advantage, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a surrogate arrangement, the plan or its medical group has the right to impose a lien against any amount received by the surrogate/ member for reasonable costs incurred by Western Health Advantage or its contracted medical groups.	✓	
Ambulance claims where transport is refused.	✓	
Any services or supplies obtained before the member's effective date of coverage.	✓	
Appliances, equipment, or supplies primarily for comfort or convenience. For example: air conditioners, humidifiers, and incontinence pads. Please note these examples are not an exhaustive list.	✓	
Autopsies and services related to autopsies.	✓	
Charges for missed appointments or completion of claim forms.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures.		✓ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Court-ordered health care services and supplies when not medically necessary.	✓	
‡ Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bath or dressing.	✓	
Dance therapy, recreation therapy, and activity therapy, such as music, dance, art or play therapies not for recreation.		✓ Unless medically necessary for severe mental illness
Direct to Consumer testing, also known as self-testing, at home testing, or over-the counter testing, that are sold directly to individuals via the Internet, television, print advertisements or other marketing materials.	✓	
Educational services including, but not limited to, for employment or professional purposes.		✓ Unless medically necessary for severe mental illness
Elective or voluntary enhancement procedures or services.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Expenses incurred obtaining copies of medical records.	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Eyeglasses cases.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Guest meals in a hospital or skilled nursing facility.	✓	
Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased.	✓	
Home birth delivery.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Hypnotherapy.		✓ Unless medically necessary for severe mental illness.
Implantable hormones.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Lens extras for cataract hardware (i.e. tints, antireflective coating, progressives, oversize lenses, etc.), unless medically necessary.		✓
Marriage counseling, except for the treatment of a mental health disorder/condition.		✓
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Non-emergency transportation.		✓ Prior authorization is Required.
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 are for a person with diabetic foot disease.
Orthoptics or vision training.	✓	
Other psychological testing, except to diagnose and/or to guide treatment of a mental health/substance abuse condition.		✓
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private duty nurses.	✓	
Private room in a hospital.		✓ Covered only when medically necessary

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Psychological examination, testing or treatment for the following purposes: licensing; or insurance, judicial or administrative proceedings (including but not limited to parole or probation proceedings); or satisfying an employer's, prospective employer's or other party's requirements for obtaining employment.	✓	
Radial keratotomy, LASIK surgery, and other low vision aids.	✓	
Repair and replacement of DME, orthotics or prosthetics when necessitated by the member's abuse or misuse. Any device not medical in nature (e.g., exercise equipment, whirlpool, spa), more than one device for the same body part, or more than one piece of equipment that serves the same function.	✓	
Replacement lenses or frames for lenses or frames that are lost, stolen or broken, unless benefits are otherwise available.	✓ When not medically necessary.	✓
Reports, evaluations, or routine physical exams primarily for insurance, licensing, employment or other third-party and non-preventive purposes.	✓	
Reversal of sterilization procedures and or nonprescription contraceptive supplies.	✓	
Routine dental care, such as cleanings, fillings or dentures.	✓	
Routine foot care.		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services and supplies associated with the donation of organs when the recipient is not a member of Western Health Advantage.	✓	
Services considered not reasonable and necessary, according to the standards of Original Medicare.	✓	
Services not covered by Medicare.	✓	
Services or supplies provided by a non-participating provider without written referral by the member's PCP outside of an emergent situation.		✓ Care by non-participating providers will only be authorized and provided as a covered service if the care is determined to be medically necessary and not available through participating providers.
Services provided in Veterans Affairs (VA) Facilities.	✓	
Services related to assisted reproductive technology. This includes, but is not limited to: harvesting or stimulation of the human ovum, ovum transplants, Gamete Intrafallopian Transfer (GIFT), donor semen or eggs (and services related to their procurement and storage), artificial insemination, including related medications, laboratory, and radiology services, services or medications to treat low sperm count, In Vitro Fertilization (IVF), Zygote Intrafallopian Transfer (ZIFT), and preimplantation genetic screening.	✓	
Services related to intrauterine devices (IUD), including insertion of the device and the device itself.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services, such as Drug claims, are excluded from your benefit if they are ordered or prescribed by you for your own benefit, or are provided or prescribed by a person who resides in your home or is a member of your family. "Member of your family" for this purpose means any person who could possibly inherit from you under the intestate succession law of any state, plus any in-law, step relative, foster parent, or domestic partner of you or of any such person.	✓	
Stress management therapy.		✓ Unless medically necessary for severe mental illness.
Subnormal vision aids, aniseikonic lenses or plain (non-prescription lenses) glasses, sunglasses, and other low vision aids and services.	✓	
Supportive devices for the feet.		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Testing for the sole purpose of determining paternity.	✓	
Treatment of short stature.		✓ Unless treatment is medically necessary
Weight control surgery or procedures including without limitation gastric bubble, gastroplasty, gastric bypass, gastric stapling, liposuction and HCG injections; and any experimental procedures for the treatment of obesity. However, medically necessary services as determined by Western Health Advantage for the treatment of morbid obesity with prior authorization are covered.		✓ May be covered if treating morbid obesity and prior authorization by Western Health Advantage

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Wilderness programs, therapeutic boarding schools, and equestrian/hippotherapy.		✓ Unless medically necessary for severe mental illness

‡ Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

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

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

Sometimes when you get medical care you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will 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.

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

When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

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

When a network provider sends you a bill you think you should not pay

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

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

If you are retroactively enrolled in our plan

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

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

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

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

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (**medicare.westernhealth.com**) or call Member Services and ask for the form. Mail your request for payment together with any bills or receipts to us at this address:

  Western Health Advantage Mail Service

  Attn: Claims
  PO Box 14952, Salem, OR 97309

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

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

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. 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 7 of this document.

Chapter 6. Your rights and responsibilities

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

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, in braille, in large print, or other alternate formats, etc.)

Your 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 a plan may meet these accessibility requirements include, but are not 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 are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Western Health Advantage. You may also file a complaint with Medicare by calling 1.800.MEDICARE (1.800.633.4227) or directly with the Office for Civil Rights 1.800.368.1019 or TTY 1.800.537.7697.

SECCIÓN 1 Nuestra aseguradora debe respetar y hacer valer sus derechos como nuestro asegurado

Sección 1.1 Debemos proporcionar información de una manera que funcione para usted (en idiomas que no sean inglés, en braille, en letra grande u otros formatos alternativos, etc.)

Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de interpretación gratuitos disponibles para responder preguntas de miembros discapacitados y que no hablan inglés. También podemos brindarle información en braille, en letra grande u otros formatos alternativos sin costo alguno, en caso lo necesite. Es nuestro deber brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar una queja formal ante Western Health Advantage.

También puede presentar una queja ante Medicare llamando al 1.800.MEDICARE (1.800.633.4227) o directamente a la Oficina de Derechos Civiles. La información de contacto se incluye en esta Evidencia de Cobertura o con este envío. Asimismo, puede comunicarse con Servicios para Miembros para obtener información adicional.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a primary care physician (PCP) in the plan's network to provide and arrange for your covered services You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from the 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.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, tells what you can do.

Section 1.3 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 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 have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first.

These exceptions are allowed or required by law.

- For example, we are required to release health information to government agencies that are checking on quality of care.
- Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

Information about your health care is protected and confidential. Western Health Advantage respects the privacy of our members and takes great care to decide when it is appropriate to share health information. To learn how we protect, use and disclose health information about our members, please review our Notice of Privacy Practices. The Notice is available at **medicare.westernhealth.com** and at the end of your new member handbook.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Western Health Advantage MyCare Select, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services (Information about our plan. This includes, for example, information about the plan's financial condition or information about our network providers.

- You have the right to get information about the qualifications of the providers 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.
- Information about why something is not covered and what you can do about it. Chapter 7 provides information on asking for a written explanation on why a medical service is not covered, or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

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

You have the right to get full information from your doctors and other health care providers. 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 of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment 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 is to be done if you are not able to make medical decisions for yourself

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form. You can get** an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members as well. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Medical Board of California at **www.mbc.ca.gov/Consumers/Complaints/** or the California State Department of Public Health at **www.cdph.ca.gov/Pages/contact_us.aspx**.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 or TTY 1.800.537.7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Member Services**
- You can **call the State Health Insurance Assistance Program**. For details go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY 1.877.486.2048.

Section 1.8 How to get more information about your rights

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

- You can **call Member Services**
- You can **call the SHIP**. For details go to Chapter 2, Section 3.
- You can contact **Medicare**.
- You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.)
- Or, you can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY 1.877.486.2048.

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services. **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document to learn what is covered for you and the rules you need to follow to get your covered services.

- Chapters 3 and 4 give the details about your medical services.
- If you have any other health insurance coverage in addition to our plan, you are required to tell us. Chapter 1 tells you about coordinating these benefits.
- Tell your doctor and other health care providers that you are enrolled in our plan.
- Show your plan membership card whenever you get your medical care
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
- To help get the best care, tell your doctors and other health providers about your health problems Follow the treatment plans and instructions that you and your doctors agree upon.
- Make sure your doctors know all of the drugs you are taking, including over-the- counter drugs, vitamins, and supplements.
- If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
- You must pay your plan premiums.
- You must continue to pay your premium for Medicare Part B to remain a member of the plan.
- For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move outside of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

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

SECTION 1 Introduction

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

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

- For some 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 of these 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the 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 simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination," and "Independent Review Organization" instead of "Independent Review Entity."
- It also uses abbreviations as little as possible.

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

SECTION 2

Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to member service for help. But in some situations you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP). Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also contact Medicare to get help. To contact Medicare:

- You can call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.
- You can also visit the Medicare website (**www.medicare.gov**).

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

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

Is your problem or concern about your benefits or coverage?
(This includes problems about whether medical care are covered or not, the way in which they are covered, and problems related to payment for medical care.)

Yes.

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

No.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

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

Coverage decisions and appeals deals with problems related to your benefits and coverage for your medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription 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 prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision.

If your doctor, whether the doctor is in our network or outside it, is unsure whether we will cover a medical service you or your doctor can also contact us and ask for a coverage decision prior to receiving the services. This is called an "advanced determination," or prior authorization. You or your doctor can also request that the response be in writing if you would like a copy of the decisions for your records. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make an initial coverage decision for you. If your plan denies the coverage asked about in the advanced determination, then your plan must issue a standardized denial notice informing you or your doctor of your right to appeal this decision.

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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is a formal process called an appeal. Appeals are discussed in the next section.

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

Making an appeal

If we make a coverage decision, whether before or after a service is needed, and you are not satisfied you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request 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 were properly following the rules. When we have completed 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeals – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal.

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

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

- **You can call us at Member Services**
- **You can 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 will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.
- For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.

You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.

- If you want a friend, relative, or another person to be your representative, call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **mywha.org/MyCareRepresentative**. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

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

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

If you're not sure which section you should be using, please call Member Services. You can also get help or information from government organizations such as your SHIP.

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

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

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

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an Appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 7 and 8 of this chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

LEGAL TERM

When a coverage decision involves your medical care, it is called an "organization determination."

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

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

A "standard coverage decision" is usually made within 14 days 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. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received.*
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor asks for the fast coverage decision, we will 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 requested.

Step 2: Ask our plan to make a coverage decision or fast 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 will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- **However,** if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint". We will 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. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint". (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 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 are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

LEGAL TERM

An appeal to the 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 days. A "fast appeal" is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal." If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

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

- If you are 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 are 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 60 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 requesting 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 you're appeal and give you our answer.

- **When our plan is 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 will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - 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 will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.

- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will 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 receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time, or if we need 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 will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

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 is not connected with us and is not 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 will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the standard appeal, if your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal."). In this case the independent review organization will send you a letter.
    - Explaining its decision.
    - Notifying you of the rights to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
    - Telling you how to file a Level 3 appeal.

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

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

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

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision To make this decision, we will check to see if the medical care you paid for is a covered service We will also check to see if you followed all 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 all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider.

If we say no to your request. If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

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

- We must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.)
- If the independent review organization decides we should pay, we must send to 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 requested to you or to the provider within 60 calendar days.

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

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

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

Within two days of being admitted to hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse) ask any hospital employee for it. If you need help, please call Member Services You can also call 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY 1.877.486.2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:
    - 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 quality of your hospital care.
    - Your right to request an immediate review of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
    - You or someone who is acting on your behalf will be asked to sign the notice.
    - Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will 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 days before your discharge date, you will get another copy before you are scheduled to be discharged.
    - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. You can also see the notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.**

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

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance

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 who are paid by the Federal government to check out and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not 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 2Act 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, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
    - If you miss the deadline for contacting the Quality Improvement Organization, and 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 6.4.

- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will 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 Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices**.

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

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

What happens if the answer is yes?

- If the review organization says *yes*, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. What happens if the answer is no?
- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their 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 that your coverage for the care ended.

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

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

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

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal This is called "upholding the decision."

- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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

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

Section 6.4 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to start your first appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

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

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

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

- **Ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

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

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

Step-by-Step: Level 2 Alternate appeal Process

The independent review organization is an independent organization hired by Medicare. It is not connected with our plan and is not 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: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

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

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

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

Section 7.1 This section is only about three services:

Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

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

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*.

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

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

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
    - The written notice tells you the date when we will stop covering the care for you.
    - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

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

You will be asked to sign the written notice to show that you received it.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance

During a Level 1 appeal the Quality Improvement Organization reviews your appeal and 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 are not 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 received (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.

Your deadline for contacting this organization.

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

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

LEGAL TERM
This notice of explanation is called the "Detailed Explanation of Non-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 may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will get the Detailed Explanation of Non-Coverage, from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their 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 is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services What happens if the reviewers say no to your appeal?
- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

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

Section 7.4 Step-by-step: 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 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

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

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

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

- **Ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines. Chapter 2 has contact information.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

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

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

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

LEGAL TERMS
The formal name for the "Independent Review Organization" is the "Independent Review Entity." It is sometimes called the "IRE."

Step-by-Step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

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

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

- **Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.**
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the Independent Review Organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If 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.
- At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive 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. Here is who handles the review of your appeal at each of these levels.

LEVEL 3 APPEAL

A judge (called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

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

LEVEL 4 APPEAL

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

If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over - Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will 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 service within 60 calendar days after receiving the Council's decision.
- If we decide to appeal the decision, we will let you know in writing.
- If the answer is no or if the Council denies the review request, the appeals process ***may* or *may not* be over**.
- If you decide to accept this decision that turns down your appeal, the appeals process is over.
- If you do not want to accept the decision, you 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 on 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.

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? Examples include waiting too long on the phone, in the waiting room, or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness **(These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)**	If you have asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: o You asked us for a "fast coverage decision" or a "fast appeal," and we have said no, you can make a complaint. o You believe we are not meeting the deadlines for coverage decisions or appeals, you can make a complaint. o You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved, you can make a complaint. o You believe we failed to meet required deadlines for forwarding your case to the independent review organization, you can make a complaint.

Section 9.2 How to make a complaint

LEGAL TERMS

- A **"complaint"** is also called a **"grievance."**
- "Making a complaint" is called "filing a grievance."
- "Using the process for complaints" is also called "using the process for filing a grievance."
- A "fast complaint" is also called an "expedited grievance."

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- If you have a complaint, you or your appointed representative may call the phone number above. You may also send your complaint in writing to the Appeals and Grievance Department at the following address: Western Health Advantage, Attn: Medicare Advantage Appeals and Grievances, 2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833.
- 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 will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint." If you have a "fast complaint," it means we will give you an answer within 24 hours.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

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

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

Or

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

Section 9.5 You can also tell Medicare about your complaint

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

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1.800.MEDICARE (1.800.633.4227). TTY/TDD users can call 1.877.486.2048.

SECTION 10 Eligibility Issues

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Health Account Management Division
Attention: Enrollment Administration
P.O. Box 942715 Sacramento, CA 94229-2715
Fax: 1.916.795.1277, or telephone the CalPERS Customer Service and Outreach Division toll free at 1.888.CalPERS 9 (or 1.888.225.7377)

CalPERS Appeal Procedure Following Disposition of Medicare's Grievance Process

If you are not satisfied with the resolution or response to your grievance or appeal, CalPERS members and their dependents have the right to file for a CalPERS Administrative Review. Prior to being eligible for the CalPERS Administrative Review, members must exhaust all available grievance and appeal options offered by the health plan and Medicare.

For benefits offered by CalPERS that are not subject to Medicare, i.e. Combined Chiropractic and Acupuncture Services, members must exhaust the Plan's grievance/appeal process before being eligible for a CalPERS Administrative Review.

CalPERS Administrative Review process

If you remain dissatisfied with the health plan's or Medicare's determination, you may request an Administrative Review. The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of our grievance denial letter. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed thirty (30) days

You may submit your request and completed Authorization form via e-mail to:

Health.Appeals@CalPERS.ca.gov;

Or, the request may be mailed to:

CalPERS Strategic Health Operations Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information we may have regarding your dispute with your request for Administrative Review, please note that we may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after we submit the information we have regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send copies of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice (i.e. quality of care, quality of service disputes, or claims subject to a Medicare appeals process).

CalPERS will attempt to provide a written determination of its Administrative Review within 60 days from the date all pertinent information is received by CalPERS.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing. You and/or your Authorized Representative must request an Administrative Hearing in writing within thirty (30) days of the date of the Administrative Review determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed thirty (30) days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to your case not previously submitted for Administrative Review or External Review.

If CalPERS accepts the request for an Administrative Hearing, it will be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you and/or your Authorized Representative may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether provided in writing to you and/or your Authorized Representative within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

You may petition the Board for reconsideration of its decision, or may appeal to the Superior Court. **You may not begin civil legal remedies until after exhausting these administrative procedures.**

Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and nonprivileged medical records from the Administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor the Administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, you may present information through the opinion of an expert, such as a Physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the Administrator will reimburse you for the costs of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon the Plan must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
Sacramento, CA 95814

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Western Health Advantage MyCare Select may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the "Annual Open Enrollment Period"). During this time review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual Enrollment Period is** September to October.
- Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

- Your membership will end in our plan when your new plan's coverage begins on January 1.

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

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

- You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (**www.medicare.gov**):
- Usually, when you have moved.
- If you have Medi-Cal (Medicaid).
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- The enrollment time periods vary depending on your situation.
- To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week.

TTY users call 1.877.486.2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **Note:** If you disenroll from Medicare prescription drug coverage 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. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.3 Where can you get more information about when you can end your membership?

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

- You can contact your employer's or union's benefit administrator.
- You can **call Member Services**
- You can find the information in the ***Medicare & You 2024*** Handbook.
- Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
- You can also download a copy from the Medicare website (**www.medicare.gov**). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048.

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

Please check with the CalPERS Health Account Management Division at 888.CalPERS (or 888.225.7377) before you disenroll from our plan. Disenrolling from our plan so you can return to Original Medicare or at any time other than CalPERS open enrollment period may result in loss of CalPERS-sponsored health coverage.

If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your group's open enrollment, our disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

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

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan.	Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare with a separate Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare without a separate Medicare prescription drug plan. Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	Send us a written request to disenroll. Contact Member Services if you need more information on how to do this. You can also contact Medicare, at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1.877.486.2048. You will be disenrolled from our plan when your coverage in Original Medicare begins. **Note:** If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

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

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

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

SECTION 5 Western Health Advantage MyCare Select must end your membership in the plan in certain situations

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

Western Health Advantage MyCare Select must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
- If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership 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 your group notifies us that they are cancelling the group contract for this plan. If your group sponsor informs this plan of your loss of eligibility for their group coverage.

Where can you get more information?

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

- You can call **Member Services** for more information).

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

Western Health Advantage MyCare Select is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1.800.MEDICARE (1.800.633.4227). 24 hours a day, 7 days a week. TTY 1.877.486.2048.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

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

Chapter 9. Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not 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, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1.800.368.1019 (TTY 1.800.537.7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **www.hhs.gov/ocr/index**.

If you have a disability and need help with access to care, please call us at Member Services If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Western Health Advantage MyCare Select, 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 Liability

This section describes your duties if you receive services for which any third party may be responsible. A "third party" is any person other than you or Western Health Advantage (the "first" and "second" parties), and includes any insurer providing any coverage available to you. Where used within this provision, "Western Health Advantage" is defined to include network hospitals, physicians, medical groups, independent practice associations and other providers that provide covered services, and their designees.

1. Once any third party is found responsible and able to pay for services you have received, Western Health Advantage will not cover those services.
2. Western Health Advantage will need detailed information from you. A questionnaire will be sent to you which must be completed and returned as soon as possible. Western Health Advantage's Recovery Agent is:

   WHA TPL
   c/o Tennant & Ingram 2101 W Street
   Sacramento, CA 95818
   916.244.3400
   916.244.3440 fax

   If you have any questions, please contact us.

If you make a claim against a third party, you must notify that party of Western Health Advantage's interest.

3. To the fullest extent permitted by Medicare, Western Health Advantage is entitled to repayment from any money recovered from a third party, whether or not the recovery is described or for something other than medical expenses and whether or not you are "made whole" for your losses. Western Health Advantage is entitled to be repaid from any workers' compensation recovery whether or not a loss is found compensable under those laws.
4. Western Health Advantage is entitled to be repaid the full value of benefits, calculated using Western Health Advantage's usual and customary charges, less a pro rata share of the expenses and attorney fees incurred to make the recovery.
5. Before accepting settlement of a third-party claim, you must notify Western Health Advantage in writing of the terms offered.
6. If Western Health Advantage is not repaid by the third party, you must repay Western Health Advantage. Western Health Advantage may request refunds from your medical providers, who will then bill you.
7. You must cooperate with Western Health Advantage in obtaining repayment. If you hire an attorney, you must require the attorney to reimburse Western Health Advantage.

8. After you receive a third-party recovery, you must pay all medical expenses for treatment of the illness or injury that Western Health Advantage would otherwise pay.
9. Only when you prove to Western Health Advantage's satisfaction that the recovery has been exhausted will Western Health Advantage again begin paying. Western Health Advantage will then pay the amount of the cost of services that exceeds the net recovery.

If you fail to repay Western Health Advantage, Western Health Advantage may recover the repayment out of future benefits owed under this Plan or refer your account to an outside collection agency to recover monies owed to Western Health Advantage.

If you do not make a claim against a responsible third-party, or fail to cooperate with Western Health Advantage in any claim you do make, Western Health Advantage may collect directly from the third party. To the fullest extent permitted by Medicare, Western Health Advantage may assume your rights against a third party, may sue the third party in your name, may intervene in any suit you bring, and place a lien on any recovery to the extent Western Health Advantage has paid benefits, or has incurred expenses to obtain a recovery.

Your failure to comply with your duties permits Western Health Advantage to deny claims arising from the condition and to terminate your coverage.

Chapter 10. Definitions of important words

Advantage Referral – In order to expand the choice of physician specialists for you, Western Health Advantage implemented a unique program called "Advantage Referral." The "Advantage Referral" program allows you to access some of the specialist physicians within your network (as listed in the *Provider Directory*), instead of limiting your access to those specialists who have a direct relationship with your PCP and medical group. While your PCP will treat most of your health care needs, if your PCP determines that you require specialty care, your PCP will refer you to an appropriate provider. Contact your PCP or refer to the *Provider Directory* to confirm that a particular specialist is available to you.

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

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

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

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

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.

You must pay the inpatient hospital copayment for each benefit period. There is no limit to the number of benefit periods.

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

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

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not 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 (or "copay") – 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 or outpatient visit. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

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

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

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

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

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

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

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

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

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

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

Home Health Aide – A person who provides services that do not 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 a special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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 2 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 5% of people with Medicare are affected, so most people will not pay a higher premium.

Independent Physician Association (IPA) – An independent physician association (IPA) is a business entity organized and owned by a network of independent physician practices.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long- term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an intermediate care facility for the mentally retarded (ICF/MR), and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. In addition to the maximum out-of-pocket amount for in- network covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

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

Medically Necessary – Services or supplies that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

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 (non-group plans) – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

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

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

"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 Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network – The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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 "network providers" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

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

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan 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.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Primary Care Physician (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. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

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

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

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

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. The plan must disenroll you if you permanently move out of the plan's service area.

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

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you. You may also qualify for a Special Enrollment Period if you experience an exceptional condition. Exceptional conditions include individuals impacted by an emergency or natural disaster, health plan or employer error, formerly incarcerated individuals, individuals losing Medi-Cal coverage, and other conditions on a case-by-case basis.

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

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

Urgently Needed Services – Covered services that are not provided to treat emergency services provided when the when network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

westernhealth
ADVANTAGE

2349 Gateway Oaks Drive, Suite 100
Sacramento, California 95833
888.WHA.PERS (888.942.7377); 711 TTY

westernhealth.com/calpers