Chapter 3: Using the plan’s coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with <plan name>. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable medical equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template*.]

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# Information about “services,” “covered services,” “providers,” “network providers,” and “network pharmacies”

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

Providers are doctors, nurses, and other people who deliver services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that deliver health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you go to a network provider, you pay nothing for covered services. The only exception is if you have a patient liability for nursing facility or waiver services. Refer to Chapter 4 [plans may insert reference, as applicable] for more information.

Network pharmaciesare pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you get. [*Insert if members have $0 copays for all prescription drugs*: When you use a network pharmacy, you pay nothing for your prescription drugs.] [*Insert if members have copays*: When you use a network pharmacy, you only pay the copay amount for your prescription drugs.]Refer to Chapter 6 [plans may insert reference, as applicable] for more information.

# Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

<Plan name> covers health care services covered by Medicare and Medicaid. This includes behavioral health and long-term services and supports.

<Plan name> will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

* The care you get must be a **plan benefit**. Refer to Chapter 4 [plans may insert reference, as applicable] for information regarding covered benefits, including the plan’s Benefits Chart.
* The care must be **medically necessary**. Medically necessary means you need services, supplies, or drugs to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
* The care you get must be prior authorized by <plan name> when required. For some services, your provider must submit information to <plan name> and ask for approval for you to get the service. This is called prior authorization. Refer to the chart in Chapter 4 [plans may insert reference, as applicable] for more information.
* You must choose a network provider to be your **primary care provider (PCP)** to manage your medical care. Although you do not need approval (called a referral) from your PCP to go to other providers, it is still important to contact your PCP before you go to a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.
* To learn more about choosing a PCP, refer to page <page number>.
* **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). Here are some cases when this rule does not apply:
* The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed caremeans, refer to Section I, page <page number>.
* If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. [*Plans must specify whether authorization must be obtained from the plan prior to seeking care.*] In this situation, we will cover the care [*insert as applicable:* as if you got it from a network provider ***or*** at no cost to you]. To learn about getting approval to go to an out-of-network provider, refer to Section D, page<page number>.
* The plan covers services you got at out-of-network Federally Qualified Health Centers, Rural Health Clinics, [and] qualified family planning providers listed in the *Provider and Pharmacy Directory* [*insert if the plan does not directly or indirectly contract with these entities and they are in the service area*: [and] certified nurse practitioners [and] certified nurse midwives].
* If you are getting assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to get the services from that out-of-network provider.
* The plan covers kidney dialysis services when you are outside the plan’s service area for a short time. You can get these services at a Medicare-certified dialysis facility.
* If you are new to our plan, you may be able to continue to go to your current out-of-network providers for a period of time after you enroll. This is called a “transition period.” For more information, go to Chapter 1 [plans may insert reference, as applicable] of this handbook and your New Member Letter.
* [Plans should add additional exceptions as appropriate.]

# Information about your care team and care manager

Your care team includes [plans should describe the care team as appropriate to the plan, making sure to emphasize that the member and family are part of the team. Also explain that the care team may ask the member questions to learn more about their condition, and provide information to help the member understand how to care for their self and how to access services, including local resources].

Your care manager helps you manage all of your providers and services. They work with your care team to make sure you get the care you need. [Plans should provide applicable information about care management, including explanations for the following subsections:]

## C1. What care management is

## C2. How you can contact your care manager

## C3. How you will interact with your care manager and care team

## C4. How you can change your care manager

# Care from primary care providers, specialists, other network providers, and out-of-network providers

## D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

### Definition of “PCP” and what a PCP does

[Plans should describe the following in the context of their plans:

What a PCP is

What types of providers may act as a PCP [Plans must indicate at a minimum: family practice, internal medicine, general practice, OB/GYN, geriatrics, pediatrics, CNP, and physician assistant. Ohio allows certain specialists to act as a PCP; plans must inform members of this and under what circumstances a specialist may be a PCP.]

The role of a PCP in:

* Coordinating covered services
* Making decisions about or obtaining prior authorization, if applicable

When a clinic can be your primary care provider (RHC/FQHC)]

### Your choice of PCP

[Plans must describe how to choose a PCP.]

### Option to change your PCP

You may change your PCP for any reason. You can change your PCP to another network PCP [insert how frequently a member may change their PCP (must be at least monthly)]. Also, it’s possible that your PCP might leave our plan’s network. If your provider leaves our network, we can help you find a new PCP.

[Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.). Plans should also describe how the plan will provide written confirmation to the member of any new PCP selection prior to or on the effective date of the change.]

## D2. Care from specialists and other network providers

A specialist is a doctor who provides health care 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 problems.
* Orthopedists care for patients with bone, joint, or muscle problems.

[Plans should describe how members access specialists and other network providers, including:

What the role (if any) of the PCP is in referring members to specialists and other providers

What the process for getting prior authorization/precertification is [Plans explain that prior authorization means that the member must get approval from the plan before getting a specific service or drug *or going to an out-of-network provider and including i*nformation about which plan entity makes the prior authorization decision (e.g., Medical Director, the plan, the PCP, or another entity.)]

Who is responsible for getting the prior authorization [Plans explain, for example, if it is the PCP or the member and refer members to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable] for information about which services require prior authorization.]

If selection of a PCP results in being limited to specific specialists or hospitals to which that PCP refers [For example, plans include information about subnetworks or referral circles].]

## D3. What to do when a provider leaves our plan

[Plans may edit this section if they are obligated under state Medicaid programs to have a transition benefit when a doctor leaves the plan.]

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

* Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
* We will make a good faith effort to give you at least 30 days’ notice so that you have time to select a new provider.
* We will help you select a new qualified provider to continue managing your health care needs.
* If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
* If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a complaint.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. [Plans should provide contact information for assistance.]

## D4. How to get care from out-of-network providers

[Tell members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network), including policies regarding access to providers outside the service area for non-emergency services and, if applicable, access to providers within and/or outside the service area for non-emergency after hours services. Describe the process for getting authorization if applicable, including who is responsible for getting it.]

If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid.

* We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid.
* If you go to a provider who is not eligible to participate in Medicare, you may have to pay the full cost of the services you get.
* Providers must tell you if they are not eligible to participate in Medicare.

# How to get long-term services and supports (LTSS)

[Plans should provide applicable information about getting LTSS.]

# How to get behavioral health services

[Plans should provide applicable information about getting behavioral health services.]

# How to get transportation services

[Plans should provide applicable information about getting transportation services including the following subsection:]

## G1. How to get transportation services

[*Plans should provide the following information:*

* telephone number to arrange
* advance notification requirements
* type of appointment available for transportation
* type of transportation provided]

In addition to the transportation assistance that <plan name> provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.

# How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

## H1. Care when you have a medical emergency

### Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

* serious risk to your health or, if pregnant, to that of your unborn child; **or**
* serious harm to bodily functions; **or**
* serious dysfunction of any bodily organ or part; **or**
* in the case of a pregnant woman in active labor, when:
* there is not enough time to safely transfer you to another hospital before delivery.
* a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

### What to do if you have a medical emergency

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital, or other appropriate setting. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP or <plan name>.
* Be sure to tell the provider that you are a <plan name> member. Show the provider your <plan name> Member ID Card.
* **As soon as possible, make sure that you tell our plan about your emergency**. We need to follow up on your emergency care. You or someone else [plans may replace “someone else” with “your care manager” or other applicable term] should call to tell us about your emergency care, usually within 48 hours. Also, if the hospital has you stay, please make sure <plan name> is called within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. [Plans must either provide the toll-free phone number and days and hours of operation or explain where to find the number (e.g., on the back the of plan’s Member ID Card).]

### Covered services in a medical emergency

[Plans may modify the following sentence to identify whether this coverage is within the United States and its territories or world-wide emergency/urgent coverage:] You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, refer to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

[Plans that offer a supplemental benefit covering world-wide emergency/urgent coverage or ambulance services outside of the United States or its territories, mention the benefit here and then refer members to Chapter 4 [plans may insert reference, as applicable] for more information.]

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

[*Plans may modify this paragraph as needed to address the post-stabilization care for your plan.*] After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible. If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call [*insert plan specific information for post stabilization services*]*.*

### What to do if you have a behavioral health emergency

[*Plans should provide applicable information about getting behavioral health emergency services.*]

### Getting emergency care if it wasn’t an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn’t really an emergency. As long as you reasonably thought your health or the health of your unborn child was in serious danger, we will cover your care.

However, after the doctor says it was notan emergency, we will cover your additional care only if:

* you go to a network provider, **or**
* the additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (Refer to the next section.)

## H2. Urgently needed care

### Definition of urgently needed care

Urgently needed care is care you get for a sudden illness, injury, or condition that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

### Urgently needed care when you are in the plan’s service area

In most situations, we will cover urgently needed care only if:

* you get this care from a network provider, **and**
* you follow the other rules described in this chapter.

However, if you can’t get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

[Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).]

### Urgently needed care when you are outside the plan’s service area

When you are outside the plan’s service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other [*insert if plan covers emergency care outside of the United States or its territories:* non-emergency] care that you get outside the United States or its territories.

[Plans that offer a supplemental benefit covering urgently needed care outside of the United States or its territories, modify this section to mention the benefit and refer members to Chapter 4 [plans may insert reference, as applicable] for more information.]

## H3. 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 <plan name>.

Please visit our website for information on how to obtain needed care during a declared disaster: <web address>. [*In accordance with 42 CFR 422.100(m), plans are required to include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost sharing without required prior authorization; terms and conditions of payment for non-contracted providers; and each declared disaster’s start and end dates.*]

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at [insert as applicable: the in-network cost-sharing rate **or** no cost to you]*.* If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

# What to do if you are billed directly for services covered by our plan

Providers should bill us for providing you covered services. You should not get a provider bill for services covered by the plan. If a provider sends you a bill for a covered service instead of sending it to the plan, you can ask us to pay the bill. Call Member Services as soon as possible to give us the information on the bill.

**You should not pay the bill yourself. If you do, the plan may not be able to pay you back.**

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you got a bill for covered services, **refer to Chapter 7** [plans may insert reference, as applicable] **to learn what to do**.

## I1. What to do if services are not covered by our plan

<Plan name> covers all services:

* that are medically necessary, **and**
* that are listed in the plan’s Benefits Chart (refer to Chapter 4 [plans may insert reference, as applicable]), **and**
* that you get by following plan rules.

If you get services that aren’t covered by our plan, **you may have to pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 [plans may insert reference, as applicable] explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan’s coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you do not have prior approval from <plan name> to go over the limit, you may have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are, how close you are to reaching them, and what your provider must do to ask to exceed the limit if they think it is medically necessary.

# Coverage of health care services covered when you are in a clinical research study

## J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare, insert:* or our plan] approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers.

[If applicable, plans should describe Medicaid’s role in providing coverage for clinical research studies.]

**You do need to tell us before you start participating in a clinical research study**. If you plan to be in a clinical research study, you or your care manager should contact Member Services to let us know you will be in a clinical trial.

## J2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

* 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 that is part of the research study.
* Treatment of any side effects and complications of the new care.

[Plans that conduct or cover clinical trials that are not approved by Medicare insert: We will pay any costs if you volunteer for a clinical research study that Medicare does not approve but that our plan approves.] If you are part of a study that Medicare [plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]has **not approved**, you will have to pay any costs for being in the study.

[If applicable, plans should describe Medicaid’s role in paying for clinical research studies.]

## J3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare and Clinical Research Studies” on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://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.

# How your health care services are covered when you get care in a religious non-medical health care institution

[If applicable, plans should revise this section as needed to describe Medicaid’s role in providing care in religious non-medical health care institutions.]

## K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

## K2. Getting 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 against getting medical treatment that is “non-excepted.”

* “Non-excepted” medical treatment is any care that is voluntary and not required by any federal, state, or local law.
* “Excepted” medical treatment is any care that is not voluntary and 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 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 applies:
* You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
* [*Omit this bullet if not applicable*]You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable]) or whether there is unlimited coverage for this benefit.]

# Durable medical equipment (DME)

## L1. DME as a member of our plan

[Plans may modify this section to reflect the plan’s coverage of DME.]

DMEmeans certain items ordered by a provider for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of <plan name>, you [insert if the plan sometimes allows transfer of ownership to the member: usually] will not own DME, no matter how long you rent it.

[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions under which and when the member can own specified DME.]

[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In certain situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.]

[If the plan never allows transfer of ownership to the member (except as noted above, for example, for prosthetics), insert:Even if you had the DME for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.]

[Plans should modify this section as necessary to explain any additional Medicaid coverage of DME.]

## L2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicareprogram, people who rent certain types of DME own it after 13 months. In a Medicare Advantageplan, the plan can set the number of months people must rent certain types of DME before they own it.

**Note:** You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 11. You can also find more information about them in the *Medicare & You 2022* handbook. If you don’t have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or 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.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

* you did not become the owner of the DME item while you were in our plan, **and**
* you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage payments do not count toward the payments you need to make after leaving our plan**.

* You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
* There are no exceptions to this case when you return to Original Medicare or Medicare Advantage plan.

## L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

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

Oxygen equipment must be returned to the owner when it’s no longer medically necessary for you or if you leave our plan.

## L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

* your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
* your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

* your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
* a new 5-year period begins.
* you will rent from a supplier for 36 months.
* your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
* a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.