Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services <plan name> covers and any restrictions or limits on those services [Insert if the plan has cost sharing: and how much you pay for each service]. It also tells you about benefits not covered under our plan. 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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# Your covered services

This chapter tells you what services <plan name> covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 [plans may insert reference, as applicable], and information about what you pay for drugs is in Chapter 6 [plans may insert reference, as applicable].

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan’s rules. Refer to Chapter 3 [plans may insert reference, as applicable] for details about the plan’s rules. However, you may be responsible for paying a “patient liability” for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at <toll-free phone number> or your care manager at [plans should include a phone number or other contact information].

## A1. During public health emergencies

[*Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.*]

<Plan name> will cover all COVID-19 testing, treatment, and vaccinations without copays.

**COVID-19 Testing**

You can find COVID-19 testing locations online at [coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers](https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers).

**COVID-19 Vaccinations**

The Ohio Department of Health (ODH) has a search tool you can use to find a vaccine provider. You can search the directory by county and ZIP code. It displays providers currently getting shipments of COVID-19 vaccines. You can get information and vaccination locations at [vaccine.coronavirus.ohio.gov/](https://vaccine.coronavirus.ohio.gov/) or by calling ODH toll-free at 833-427-5634.

<Plan name> can help you find a testing or vaccination location in your community. They also can help with scheduling and transportation to your appointment. Use the information at the bottom of the page to contact <plan name> Member Services or the Nurse Advice Hotline at <phone number>.

ODH gives regular updates on vaccination eligibility phases at [coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program](https://coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program).

# Rules against providers charging you for services

Except as indicated above, we do not allow <plan name> providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a covered service.

**You should never get a bill from a provider for a covered service.** If you do, refer to Chapter 7 [plans may insert reference, as applicable] or call Member Services.

# Our plan’s Benefits Chart

The following Benefits Chart in Section D is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. [Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.] If you can’t find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your care manager.

**We will cover the services listed in the Benefits Chart only when the following rules are met:**

* Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a 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.
* If <plan name> makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, refer to Chapter 9 [plans may insert reference, as applicable].
* You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.
* You have a primary care provider (PCP) or a care team that is providing and managing your care.
* Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to get the service. If you are not sure whether a service requires PA, contact Member Services or visit our website at [insert plan website link where the member can view the PA list].
* [Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI)”* in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [*insert if applicable:* and/or reduced cost sharing]:
  + [*List all applicable chronic conditions here.*]
  + [If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]

Please refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

[Instructions on completing the Benefits Chart:

* For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.
* Plans must include any services provided in excess of the Medicare and Medicaid requirements.
* Plans must clearly indicate in the Limitations and Exceptions column whether benefits are subject to PA, a doctor’s order, or require a prescription. (This can be done with asterisks, footnotes, bold type, or italic type. Plans should select only onemethod of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)
* Plans may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Benefits Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member’s access to services within the chart. Any hard limits for services must indicate that members under the age of 21 may be able to get services beyond the hard limit if medically necessary.
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the allowed benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
* *Deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the “Uniformity Flexibility” benefits for which they are eligible.*
* *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.*]

# The Benefits Chart

[*When a benefit continues from one page to the next, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description:* **This benefit is continued on the next page*.*** *At the top of the next page where the benefit description continues, plans enter the benefit name again in bold followed by* **(continued).** *Plans may refer to* **Durable medical equipment (DME) and related supplies** *and other examples later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.*]

## D1. Preventive Visits

[Plans should modify this table to reflect supplemental benefits as appropriate.]

| Services covered by our plan | Limitations and exceptions |
| --- | --- |
| Annual checkup  This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months.  **Note**: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. |  |
| “Welcome to Medicare” visit  If you have been in Medicare Part B for 12 months or less, you can get a one-time “Welcome to Medicare” preventive visit. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. This visit includes:   * a review of your health, * education and counseling about the preventive services you need (including screenings and shots), **and** * referrals for other care if you need it. |  |
| Well child check-up (also known as Healthchek)  Healthchek is Ohio’s early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests. |  |

## D2. Preventive Services and Screenings

[Plans should modify this table to reflect supplemental benefits as appropriate.]

| Services covered by our plan | Limitations and exceptions |
| --- | --- |
| Abdominal aortic aneurysm screening  The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk. |  |
| Alcohol misuse screening and counseling  The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner. |  |
| Breast cancer screening  The plan covers the following services:   * one baseline mammogram between the ages of 35 and 39 * one screening mammogram every 12 months for women age 40 and older * women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms * annual clinical breast exams |  |
| Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may:   * discuss aspirin use, * check your blood pressure, **or** * give you tips to make sure you are eating well. |  |
| Cardiovascular (heart) disease testing  The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease. |  |
| Cervical and vaginal cancer screening  The plan covers pap tests and pelvic exams annually for all women. |  |
| Colorectal cancer screening  The plan will pay for the following services:  Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.  Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.  Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.  Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.  Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.  Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.  Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.  As of January 1, 2023, colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. |  |
| Counseling and interventions to stop smoking or tobacco use  The plan covers tobacco cessation counseling and intervention. |  |
| Depression screening  The plan covers depression screening. |  |
| Diabetes screening  The plan covers diabetes screening (includes fasting glucose tests).  You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose). |  |
| HIV screening  The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection. |  |
| Immunizations  The plan covers the following services:   * vaccines for children under age 21 * 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 or Medicaid coverage rules * other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more. |  |
| Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:   * are aged 50-77, **and** * have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** * have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.   After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [List any additional benefits offered.] |  |
| Medicare Diabetes Prevention Program (MDPP)  The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:   * long-term dietary change, **and** * increased physical activity, **and** * ways to maintain weight loss and a healthy lifestyle. |  |
| Obesity screening and therapy to keep weight down  The plan covers counseling to help you lose weight. |  |
| Prostate cancer screening  The plan covers the following services:   * a digital rectal exam * a prostate specific antigen (PSA) test |  |
| Sexually transmitted infections (STIs) screening and counseling  The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B.  The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. |  |

## D3. Other Services

[Plans should modify this table to reflect supplemental benefits as appropriate.]

| Services covered by our plan | Limitations and exceptions |
| --- | --- |
| Acupuncture  The plan covers acupuncture for pain management of headaches, lower back pain, neck pain, osteoarthritis of the hip or knee, nausea or vomiting related to pregnancy or chemotherapy, and acute post-operative pain.  The plan will also pay for up to 12 visits in 90 days if you have chronic low back pain, defined as:   * lasting 12 weeks or longer; * not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); * not associated with surgery; **and** * not associated with pregnancy.   The plan will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments each year for chronic low back pain.  Acupuncture treatments for chronic low back pain must be stopped if you don’t get better or if you get worse.  [*List any additional benefits offered.*] | Authorization is required for more than 30 acupuncture visits per benefit year. |
| Ambulance and wheelchair van services  Covered emergency ambulance transport services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.  Your condition must be serious enough that other ways of getting to a place of care could risk your health or, if you are pregnant, your unborn baby’s life or health.  In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary. |  |
| Chiropractic services  The plan covers:   * diagnostic x-rays * adjustments of the spine to correct alignment   [List any additional benefits offered. Also, list any restrictions, such as the maximum number of visits.] |  |
| Dental services  The plan covers the following services:   * comprehensive oral exam (one per provider-patient relationship) * periodic oral exam once every 180 days for members under 21 years of age, and once every 365 days for members age 21 and older * preventive services including prophylaxis, fluoride for members under age 21, sealants, and space maintainers * routine radiographs/diagnostic imaging * comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services   [List any additional benefits offered or modify language above as necessary to reflect additional benefits offered.]  We pay for some dental services when the service is an integral part of specific treatment of a beneficiary’s primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. |  |
| Diabetic services  The plan covers the following services for all people who have diabetes (whether they use insulin or not):   * training to manage your diabetes, in some cases * supplies to monitor your blood glucose, including: * blood glucose monitors and test strips * lancet devices and lancets * glucose-control solutions for checking the accuracy of test strips and monitors * for people with diabetes who have severe diabetic foot disease: * one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** * one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)   The plan also covers fitting the therapeutic custom-molded shoes or depth shoes.  [List any additional benefits offered.] |  |
| Durable medical equipment (DME) and related supplies  Covered DME includes, but is not limited to, the following:   * 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 * walkers   Other items (such as incontinence garments, enteral nutritional products, ostomy and urological supplies, and surgical dressings and related supplies) may be covered. For additional types of supplies that the plan covers, refer to the sections on diabetic services, hearing services, and prosthetic devices.  The plan may also cover learning how to use, modify, or repair your item. Your care team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert: We will cover all DME that Medicare and Medicaid usually cover. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  This benefit is continued on the next page |  |
| Durable medical equipment (DME) and related supplies (continued)  [Plans that limit the DME brands and manufacturers that you will cover, insert the following (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.): With this Member Handbook, we sent you <plan name>’s list of DME. The list tells you the brands and makers of DME that we will cover. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  Generally, <plan name> covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to <plan name> and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)  If you (or your doctor) do not agree with the plan’s coverage decision, you or your doctor may file an appeal. You can also file an appeal if you do not agree with your doctor’s decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9 [plans may insert reference, as applicable].)]  [Plans that limit the DME brands and manufacturers must include on their DME list information regarding the requirement to cover a brand not on the list for up to 90 days for new members.] |  |
| Emergency care (refer to also “urgently needed care”)  Emergency care means services that are:   * given by a provider trained to give emergency services, **and** * needed to treat a medical emergency.   A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, 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 to that of your unborn child.   In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting.  If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do.  [Also, identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.] | If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [*plans should insert information as needed to accurately describe emergency care benefits*: (e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.)]. |
| [Plans should modify this section as necessary.]  Family planning services  The plan covers the following services:   * family planning exam and medical treatment * family planning lab and diagnostic tests * family planning methods (birth control pills, patch, ring, IUD, injections, implants) * family planning supplies (condom, sponge, foam, film, diaphragm, cap) * counseling and diagnosis of infertility, and related services * counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions * treatment for sexually transmitted infections (STIs) * treatment for AIDS and other HIV-related conditions * voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) * screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders * treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)   **Note:** You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the *Provider and Pharmacy Directory*. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider. |  |
| Federally Qualified Health Centers  The plan covers the following services at Federally Qualified Health Centers:   * office visits for primary care and specialist services * physical therapy services * speech pathology and audiology services * dental services * podiatry services * optometric and/or optician services * chiropractic services * transportation services * mental health services   **Note:** You can get services from a network or out-of-network Federally Qualified Health Center. |  |
| [If this benefit is not applicable, plans should delete this row.]  Health and wellness education programs  [These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. Describe the nature of the programs here.] |  |
| Hearing services and supplies  The plan covers the following:   * hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider) * hearing aids, batteries, and accessories (including repair and/or replacement) * conventional hearing aids are covered once every 4 years * digital/programmable hearing aids are covered once every 5 years   [List any additional benefits offered or modify language above as necessary to reflect additional benefits offered.] |  |
| [If this benefit is not applicable, plans should delete this row.]  Help with certain chronic conditions  [Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or “Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.] |  |
| Home and community-based waiver services  The plan covers the following home and community-based waiver services:   * adult day health services * alternative meals service * assisted living services * choices home care attendant * chore services * community transition * enhanced community living services * home care attendant * home delivered meals * home medical equipment and supplemental adaptive and assistive device services * home modification, maintenance, and repair * homemaker services * independent living assistance * nutritional consultation * out-of-home respite services * personal care aide services * personal emergency response services * pest control * social work counseling * waiver nursing services * waiver transportation | These services are available only if your need for long-term care has been determined by Ohio Medicaid.  You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Home health services  The plan covers the following services provided by a home health agency:   * home health aide and/or nursing services * physical therapy, occupational therapy, and speech therapy * private duty nursing (may also be provided by an independent provider) * home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally * medical and social services * medical equipment and supplies |  |
| Home infusion therapy  The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:   * the drug or biological substance, such as an antiviral or immune globulin; * equipment, such as a pump; **and** * supplies, such as tubing or a catheter.   The plan will cover home infusion services that include but are not limited to:   * professional services, including nursing services, provided in accordance with your care plan; * member training and education not already included in the DME benefit; * remote monitoring; **and** * monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.   [List any additional benefits offered.] | [List copays.]  [List copays for additional benefits.] |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Hospice care  You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will cover the following while you are getting hospice services:   * drugs to treat symptoms and pain * short-term respite care * home care * nursing facility care   **Hospice services and services covered by Medicare Part A or B are billed to Medicare:**   * Refer to Section F of this chapter for more information.   **For services covered by <plan name> but not covered by Medicare Part A or B:**   * <Plan name> will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services.   **For drugs that may be covered by <plan name>’s Medicare Part D benefit:**   * Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plans may insert reference, as applicable].   This benefit is continued on the next page | If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. |
| Hospice care (continued)  **Note:** Except for emergency/urgent care, if you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should include a phone number or other contact information.]  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
| Inpatient behavioral health services  The plan covers the following services:   * inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital * For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit * inpatient detoxification care |  |
| Inpatient hospital care  The plan covers the following services, and maybe other services not listed here:   * semi-private room (or a private room if it is 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 * needed surgical and medical supplies * appliances, such as wheelchairs for use in the hospital * operating and recovery room services * physical, occupational, and speech therapy * inpatient substance use disorder services * blood, including storage and administration * physician/provider services * in some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral   **This benefit is continued on the next page** |  |
| Inpatient hospital care (continued)  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If <plan name> provides transplant services at a distant location outside the pattern of care for your community and you choose to get your transplant there, we will arrange or cover lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.] |  |
| [Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate.]  Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay  If your inpatient stay is not reasonable and necessary, the plan will not cover it.  However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:   * doctor 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 for fractures and dislocations   **This benefit is continued on the next page** |  |
| Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued)   * prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: * replace all or part of an internal body organ (including contiguous tissue), **or** * replace all or part of the function of an inoperative or malfunctioning internal body organ. * leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition * physical therapy, speech therapy, and occupational therapy |  |
| Kidney disease services and supplies  The plan covers the following services:   * kidney disease education services to teach kidney care and help you make good decisions about your care * outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable]*,* 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, including training for you and anyone helping you with your home dialysis treatments * home dialysis equipment and supplies * certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply   **Note**: Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart. |  |
| Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [insert as appropriate: referred **or** ordered] by your doctor.  The plan covers three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that.  [List any additional benefits offered.] | [Provide information on the circumstances under which the member may get additional hours of treatment if condition, treatment, or diagnosis changes, and whether PA or a provider order is required.] |
| Medicare Part B prescription drugs  [*Plans that will or expect to use Part B step therapy should indicate the Part B drug categories below that will or may be subject to Part B step therapy as well as a link to a list of drugs that will be subject to Part B step therapy. The link may be updated throughout the year and any changes added at least 30 days prior to implementation per 42 CFR 422.111(d).*]  These drugs are covered under Part B of Medicare. <Plan name> covers the following drugs:   * drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services * insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) * other 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 * osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself * 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 [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) * IV immune globulin for the home treatment of primary immune deficiency diseases   **This benefit is continued on the next page** |  |
| Medicare Part B prescription drugs (continued)  [Insert if applicable: The following link will take you to a list of Part B drugs that may be subject to step therapy: <hyperlink>.]  We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.  Chapter 5 [plans may insert reference, as applicable] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [plans may insert reference, as applicable] explains what you pay for your outpatient prescription drugs through our plan. |  |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Mental health and substance use disorder services at addiction treatment centers  The plan covers the following services at addiction treatment centers:   * ambulatory detoxification * assessment * case management * counseling * crisis intervention * intensive outpatient * alcohol/drug screening analysis/lab urinalysis * medical/somatic * methadone administration * office administered medications for addiction including vivitrol and buprenorphine induction   Refer to “Inpatient behavioral health services” and “Outpatient mental health care” for additional information. |  |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Mental health and substance use disorder treatment services at community mental health centers  The plan covers the following services at certified community mental health centers:   * mental health assessment/diagnostic psychiatric evaluation * Assertive Community Treatment (ACT) * Intensive Home Based Treatment (IHBT) * Screening, Brief Intervention and Referral to Treatment (SBIRT) * psychological Testing * Therapeutic Behavioral Services (TBS) * psychosocial Rehabilitation * Community psychiatric supportive treatment (CPST) services * counseling and therapy * crisis intervention * pharmacological management * certain office administered injectable antipsychotic medications * partial hospitalization for Substance Use Disorder only   Partial hospitalization is a structured program of active substance use disorder treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor’s or therapist’s office. Refer to “Inpatient behavioral health services” and “Outpatient mental health care” for additional information. |  |
| Nursing and skilled nursing facility (SNF) care  The plan covers the following services, and maybe other services not listed here:   * a semi-private room, or a private room if it is medically necessary * meals, including special diets * nursing services * physical therapy, occupational therapy, and speech therapy * drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors * blood, including storage and administration * medical and surgical supplies given by nursing facilities * lab tests given by nursing facilities * x-rays and other radiology services given by nursing facilities * durable medical equipment, such as wheelchairs, usually given by nursing facilities * physician/provider services   You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get Medicaid nursing facility care from the following place if it accepts our plan’s amounts for payment:   * a nursing home or continuing care retirement community where you lived on the day you became a <plan name> member   You can get Medicare nursing facility care from the following places if they accept our plan’s amounts for payment:   * a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) * a nursing facility where your spouse or domestic partner lives at the time you leave the hospital | You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.  Note that patient liability does not apply to Medicare-covered days in a nursing facility. |
| Opioid treatment program (OTP) services  The plan will pay for the following services to treat opioid use disorder (OUD):   * intake activities * periodic assessments * medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications * substance use counseling * individual and group therapy * testing for drugs or chemicals in your body (toxicology testing)   [List any additional benefits offered, with the exception of meals and transportation.] |  |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Outpatient mental health care  The plan covers mental health services provided by:   * a state-licensed psychiatrist or doctor, * a clinical psychologist, * a clinical social worker, * a clinical nurse specialist, * a licensed professional counselor (LPC) * a licensed marriage and family therapist (LMFT) * a nurse practitioner (NP), * a physician assistant (PA), **or** * any other qualified mental health care professional as allowed under applicable state laws.   The plan covers the following services, and maybe other services not listed here:   * Clinic services and general hospital outpatient psychiatric services [Plans should include any Medicaid limitations that apply (e.g., number of visits)] * Therapeutic Behavioral Services (TBS) * Psychosocial rehab services [Plans should include any Medicaid limitations that apply (e.g., number of visits)]   [List any additional benefits offered.] |  |
| Outpatient services  The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury.  The following are examples of covered services:   * services in an emergency department or outpatient clinic, such as outpatient surgery or observation services * Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” * Sometimes you can be in the hospital overnight and still be an “outpatient.” * You can get more information about being an inpatient or an outpatient in this fact sheet: [www.medicare.gov/media/11101](https://www.medicare.gov/media/11101) * the plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers * chemotherapy * labs and diagnostic tests (for example urinalysis) * mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it * imaging (for example x-rays, CTs, MRIs) * radiation (radium and isotope) therapy, including technician materials and supplies * blood, including storage and administration * medical supplies, such as splints and casts * preventive screenings and services listed throughout the Benefits Chart * some drugs that you can’t give yourself   [List any additional benefits offered.] |  |
| Physician/provider services, including doctor’s office visits  The plan covers the following services:   * health care or surgery services given in places such as a physician’s office, certified ambulatory surgical center, or hospital outpatient department * consultation, diagnosis, and treatment by a specialist * [Insert if providing any additional telehealth benefits consistent with 42 CFR §422.135 in the plan’s approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].]   + 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. [Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]   + [List the available means of electronic exchange used for each Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.] * [*Insert if the plan’s service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act:* Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]   **This benefit is continued on the next page** |  |
| Physician/provider services, including doctor’s office visits (continued)   * telehealth services for monthly end-stage renal disease (ESRD) 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 * telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:   + you have an in-person visit within 6 months prior to your first telehealth visit   + you have an in-person visit every 12 months while receiving these telehealth services   + exceptions can be made to the above for certain circumstances * telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers * virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:   + you’re not a new patient **and**   + the check-in isn’t related to an office visit in the past 7 days **and**   + 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:   + you’re not a new patient **and**   + the evaluation isn’t related to an office visit in the past 7 days **and**   + the evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment   **This benefit is continued on the next page** |  |
| Physician/provider services, including doctor’s office visits (continued)   * consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient * second opinion [insert if appropriate: by another network provider] before 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,   + pulling teeth before radiation treatments of neoplastic cancer, **or**   + services that would be covered when provided by a physician.   [List any additional benefits offered.] |  |
| Podiatry services  The plan covers the following services:   * diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma * routine foot care for members with conditions affecting the legs, such as diabetes   [List any additional benefits offered.] |  |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Prosthetic devices and related supplies  Prosthetic devices replace all or part of a body part or function. The following are examples of covered prosthetic devices:   * colostomy bags and supplies related to colostomy care * pacemakers * braces * prosthetic shoes * artificial arms and legs * breast prostheses (including a surgical brassiere after a mastectomy) * dental devices   The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices.  The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section [plans may insert reference, as applicable] for details. |  |
| Rehabilitation services   * outpatient rehabilitation services * The plan covers physical therapy, occupational therapy, and speech therapy. * You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. * cardiac (heart) rehabilitation services * The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. * The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. * pulmonary rehabilitation services * The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).   [List any additional benefits offered.] |  |
| Rural Health Clinics  The plan covers the following services at Rural Health Clinics:   * office visits for primary care and specialist services * clinical psychologist * clinical social worker for the diagnosis and treatment of mental illness * visiting nurse services in certain situations   **Note**: You can get services from a network or out-of-network Rural Health Clinic. |  |
| Specialized Recovery Services (SRS) Program  If you are an adult who has been diagnosed with a severe and persistent mental illness and you live in the community, you may be eligible to get SRS specific to your recovery needs. The plan covers the following three services if you are enrolled in the SRS program:   * Recovery Management – Recovery managers will work with you to: * develop a person-centered care plan which reflects your personal goals and desired outcomes, * regularly monitor your plan through regular meetings, **and** * provide information and referrals. * Individualized Placement and Support-Supported Employment (IPS-SE) – Supported employment services can: * help you find a job if you are interested in working, * evaluate your interests, skills, and experiences as they relate to your employment goals, **and** * provide ongoing support to help you stay employed. * Peer Recovery Support: * peer recovery supporters use their own experiences with mental health and substance use disorders to help you reach your recovery goals, **and** * goals are included in a care plan you design based on your preferences and the availability of community and supports.   The peer relationship can help you focus on strategies and progress towards self-determination, self-advocacy, well-being and independence. | If you are interested in SRS, you will be connected with a recovery manager who will begin the assessment for eligibility looking at things such as your diagnosis and your need for help with activities such as medical appointments, social interactions and living skills. |
| Supervised exercise therapy (SET)  The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) [*insert if applicable:* who have a referral for PAD from the physician responsible for PAD treatment]. The plan will pay for:   * up to 36 sessions during a 12-week period if all SET requirements are met * an additional 36 sessions over time if deemed medically necessary by a health care provider   The SET program must be:   * 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) * in a hospital outpatient setting or in a physician’s office * delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD * under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques |  |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Transportation for non-emergency services (also refer to “Ambulance and wheelchair van services”)  If you must travel 30 miles or more from your home to get covered health care services, <plan name> will provide transportation to and from the provider’s office.  **Note**: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. |  |
| Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency, **or** * a sudden medical illness, **or** * an injury, **or** * a condition that needs care right away.   If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan’s service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).  [Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.] |  |
| [Plans should modify this section to reflect supplemental benefits as appropriate.]  Vision care  The plan covers the following services:   * one comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered: * per 12-month period for members under 21 and over 59 years of age; **or** * per 24-month period for members 21 through 59 years of age. * vision training * services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: * annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration * One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, members with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 and older. * One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) |  |

# Services when you are away from home or outside of the service area

If you are away from home or outside of our service area (refer to Chapter 1 [plans may insert reference, as applicable]) and need medical care [plans must explain the available services, including at a minimum emergency and urgent services, and how to access services].

[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:

If you are out of the plan’s service area for more than 6 months at a time but do not permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program [specify areas where the visitor/traveler program is being offered] that will allow you to remain enrolled in our plan when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you can get all plan-covered services at in-network cost sharing prices. You can contact the plan for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you have not returned to the plan’s service area by <end date>, you will be dropped from the plan.]

# Benefits covered outside of <plan name>

The following services are not covered by <plan name> but are available through Medicare. Call Member Services to find out about services not covered by <plan name> but available through Medicare.

## F1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what <plan name> pays for while you are getting hospice care services.

**For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:**

* The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

**For services covered by Medicare Part A or B that are not related to your terminal prognosis:**

* The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

**For drugs that may be covered by <plan name>’s Medicare Part D benefit:**

* Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [*plans may insert reference, as applicable*].

**Note:** If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [*Plans should include a phone number or other contact information for the care manager.*]

# Benefits not covered by <plan name>, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not cover these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9 [plans may insert reference, as applicable].

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

[The services listed in the remaining bullets are excluded from Medicare’s and Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or under a State’s demonstration, or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plans may also add exclusions as needed.]

* Services considered not “reasonable and necessary,” according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
* Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 [plans may insert reference, as applicable] for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
* Surgical treatment for morbid obesity, except when it is medically necessary and Medicare covers it.
* A private room in a hospital, except when it is medically necessary.
* Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
* Inpatient hospital custodial care.
* Full-time nursing care in your home.
* Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
* Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.
* Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines.
* Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
* Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
* Infertility services for males or females.
* Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
* Reversal of sterilization procedures and non-prescription contraceptive supplies.
* Paternity testing.
* Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
* Naturopath services (the use of natural or alternative treatments).
* Services provided to veterans in Veterans Affairs (VA) facilities.
* Services to find cause of death (autopsy).