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 termsand theirdefinitions 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 [insert if the plan has cost sharing: and your out-of-pocket costs]

This chapter tells you what services <plan name> covers. [Insert if the plan has cost sharing: It also tells how much you pay for each service.] You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 [plans may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.]

[Plans with cost sharing, insert: For some services, you will be charged an out-of-pocket cost called a copay. This is a fixed amount (for example, $5) you pay each time you get that service. You pay the copay at the time you get the medical service.]

[Plans with coinsurance, insert: For some services, you will be charged an out-of-pocket amount called coinsurance. This is a percentage of the cost of the service that you will need to pay at the time you get the service.]

[Plans with **no** cost sharing for any services described in this chapter, insert: Because you get assistance from Medicaid, you pay nothing for your covered services 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.]

If you need help understanding what services are covered, call your [plans may insert: care coordinator and/or Member Services] at <Member Services toll-free number> from <Member Services call center days and hours of operation>. TTY users should call <Member Services toll-free TTY phone number>. [Plans should replace the term “care coordinator” with the term they use and 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.*]

# Rules against providers charging you for services

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 service.

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

# Our plan’s Benefits Chart

[Plans may add references to long-term care or home and community-based services.]

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections, General Services offered to all enrollees, and Home and Community-based Services offered to enrollees who qualify through a home and community-based services waiver program. [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.]

**We will pay for the services listed in the Benefits Chart only when the following rules are met.** [Plans that do not have cost sharing, insert: You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.]

* Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need services 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 or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.
* [Insert if 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.]
* [Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan’s network. This is called a referral. Chapter 3 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.]
* [Insert if applicable: 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. Covered services that need prior authorization are marked in the Benefits Chart [insert as appropriate: by an asterisk (\*) **or** by a footnote **or** in bold type **or** in italic type].] [Insert if applicable: In addition, you must get prior authorization for the following services that are not listed in the Benefits Chart: [insert 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.]

* [Insert as applicable: Most **or** All] preventive services are free. You will find this apple Apple icon represents preventive services next to preventive services in the Benefits Chart.

[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.
* Include the following where appropriate: You should talk to your provider and get a referral.
* Plans must include any services provided in excess of the Medicare and Medicaid requirements. Preventive services must be identified with the apple icon.
* Plans should clearly indicate which benefits are subject to prior authorization. (This can be done with asterisks, footnotes, bold type, or italic type. Plans should select only one method 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.
* 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 benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans should include all non-waiver LTSS in the chart in alphabetical order.
* 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* **Medical equipment 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.*]

| Services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Red apple appears on the left side of the table next to preventive services | Abdominal aortic aneurysm screening  The plan will cover a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Acupuncture for chronic low back pain  The plan will 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 if you show improvement. You may not get more than 20 acupuncture treatments each year.  Acupuncture treatments must be stopped if you don’t get better or if you get worse.  [*List any additional benefits offered.*] | $0  [*List copays for additional benefits.*] |
| Red apple appears on the left side of the table next to preventive services | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Alcohol misuse screening and counseling  The plan covers one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.  If you screen positive for alcohol misuse, the plan covers up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.  [List any additional benefits offered.] | $0 |
|  | Ambulance services  Covered ambulance 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 life or health. Ambulance services for other cases must be approved by the plan.  In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | $0 |
| Red apple appears on the left side of the table next to preventive services | Annual wellness visit  If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will cover this 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. | $0 |
| Red apple appears on the left side of the table next to preventive services | Bone mass measurement  The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.  The plan will cover the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Breast cancer screening (mammograms)  The plan will cover 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 * Clinical breast exams once every 24 months   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Cardiac (heart) rehabilitation services  The plan covers cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s [insert as appropriate: referral **or** order].  The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
| Red apple appears on the left side of the table next to preventive services | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan covers one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:   * discuss aspirin use, * check your blood pressure, **or** * give you tips to make sure you are eating well.   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Cardiovascular (heart) disease testing  The plan covers blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. Additional testing may be covered if deemed medically necessary by your primary care provider.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Cervical and vaginal cancer screening  The plan covers the following services:   * For all women: Pap tests and pelvic exams once every 12 months   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Chiropractic services  The plan covers adjustments of the spine to correct alignment.  [List any plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | [List copays.]  [List copays for supplemental benefits.] |
| Red apple appears on the left side of the table next to preventive services | Colorectal cancer screening  The plan covers the following services:   * Flexible sigmoidoscopy (or screening barium enema) every 48 months * Fecal occult blood test, every 12 months * Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months * DNA-based colorectal screening, every 3 years * Screening colonoscopy * For people at high risk of colorectal cancer, the plan will cover one screening colonoscopy (or screening barium enema) every 24 months. * For people not at high risk of colorectal cancer, the plan will cover one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).   Additional screenings may be covered if deemed medically necessary by your primary care provider.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Counseling to stop smoking or tobacco use  If you use tobacco but do not have signs or symptoms of tobacco-related disease:   * The plan will cover two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * The plan will cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits.   If you use tobacco and are pregnant:   * The plan will cover three counseling quit attempts within a 12 month period. This service is free for you. Each counseling attempt includes up to four face-to-face visits.   [List any additional benefits offered.] | $0  [List copays for supplemental benefits.] |
|  | Dental services  The plan covers the following dental services:   * Limited and comprehensive exams * Restorations * Dentures * Extractions * Sedation * Dental emergencies * Dental services necessary for the health of a pregnant woman prior to delivery of her baby   [List any plan-covered supplemental benefits offered, such as routine dental care, dental X-rays, and cleanings.] | [List copays.] |
| Red apple appears on the left side of the table next to preventive services | Depression screening  The plan will cover one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Diabetes screening  The plan will cover this screening (includes fasting glucose tests) if you have any of the following risk factors:   * High blood pressure (hypertension) * History of abnormal cholesterol and triglyceride levels (dyslipidemia) * Obesity * History of high blood sugar (glucose)   Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Diabetic self-management training, services, and supplies  The plan will cover the following services for all people who have diabetes (whether they use insulin or not):   * Supplies to monitor your blood glucose, including the following: * A blood glucose monitor * Blood glucose 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, the plan will cover the following: * 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 will also cover fitting the therapeutic custom-molded shoes or depth shoes.   * The plan will cover training to help you manage your diabetes, in some cases.   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Emergency 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 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.   [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.] | $0  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 as necessary.]  Family planning services  The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office.  The plan will cover 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 with prescription (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) * 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.) * Genetic counseling * Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy   The plan will also cover some other family planning services. However, you must use a provider in the plan’s network for the following services:   * Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) * Fertility preservation services * Treatment for AIDS and other HIV-related conditions * Genetic testing | [List copays.] |
|  | **Gender-affirming services**  For members with a diagnosis of gender dysphoria, the plan covers gender-affirming services. Some screenings and services are subject to prior authorization and referral requirements.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | [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.] | [List copays.] |
|  | [Plans that cover hearing services as a Medicaid benefit should modify the following description if necessary. Add the apple icon if listing only preventive services.]  Hearing services  The plan covers hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  The plan also covers the following:   * Basic and advanced hearing tests * Hearing aid counseling * Fitting/evaluation for a hearing aid * Hearing aids once every three years * Hearing aid batteries and accessories * Hearing aid repair and replacement of parts   [List any additional benefits offered.] | [List copays.]  [List copays for additional benefits.] |
|  | [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.] | [List copays.] |
| Red apple appears on the left side of the table next to preventive services | HIV screening  The plan pays for one HIV screening exam every 12 months for people who:   * ask for an HIV screening test, **or** * are at increased risk for HIV infection.   For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Home health agency care  [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.  The plan will cover the following services, and maybe other services not listed here:   * Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies | [List copays.] |
|  | **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.] |
|  | Hospice care  You can get care from any hospice program certified by Medicare. 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. 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, including home health aide services * Occupational, physical and speech-language therapy services to control symptoms * Counseling services   **This benefit is continued on the next page** | [List copays.] |
|  | Hospice care (continued)  **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. You pay [insert as appropriate: the plan’s cost sharing amount ***or*** 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 coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should replace the term “care coordinator” with the term they use and 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.] |  |
| Red apple appears on the left side of the table next to preventive services | Immunizations  The plan will cover the following services:   * Pneumonia vaccine * Flu shots, once each flu season, in the fall and winter, with additional flu shots if medically necessary * Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B * Other vaccines if you are at risk and they meet Medicare Part B coverage rules   The plan will cover other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Inpatient hospital care  [List any restrictions that apply.]  The plan will cover 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   **This benefit is continued on the next page** | $0  You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. |
|  | Inpatient hospital care (continued)   * Needed surgical and medical supplies * Appliances, such as wheelchairs * Operating and recovery room services * Physical, occupational, and speech therapy * Inpatient substance abuse services * Blood, including storage, blood components and administration thereof * Physician 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.   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 outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.] |  |
|  | Inpatient mental health care  The plan will cover medically necessary psychiatric inpatient care at approved institutions. | $0 |
|  | [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 pay for 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 * 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 | $0 |
|  | Kidney disease services and supplies  The plan will cover the following services:   * Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. * Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable] * 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   Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart. | $0 |
| Apple icon indicates preventive services. | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:   * Are aged 55-77, 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 30 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.] | $0  [List copays for additional benefits.] |
|  | [Plans that cover durable medical equipment as a Medicaid benefit should modify the following description if necessary.]  Medical equipment and related supplies  The following general types of services and items are covered:   * Nondurable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy * Durable medical equipment (DME), such as wheelchairs, crutches, power mattress systems, diabetic supplies, walkers, hospital beds ordered by a provider for use in the home, Intravenous (IV) infusion pumps, humidifiers, speech generating devices, and walkers (for a definition of “Durable medical equipment,” refer to Chapter 12 [plans may insert reference, as applicable] of this handbook) * Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports, foot inserts * Respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment * Repair of durable medical equipment, prosthetic devices and orthotic devices * Rental of medical equipment under circumstances where patient’s needs are temporary   To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Medicaid usually pay for. 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.]  [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 pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  **This benefit is continued on the next page** | [List copays.] |
|  | Medical equipment and related supplies (continued)  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 pay for 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 <plan name>’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].)] |  |
| Apple icon indicates preventive services. | 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 will cover 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. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s [insert as appropriate: referral **or** order]. A doctor must prescribe these services and renew the [insert as appropriate: referral **or** order] each year if your treatment is needed in the next calendar year.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | 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. | $0 |
|  | 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> will cover 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 * 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   **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B prescription drugs (continued)**   * 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   [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. |  |
|  | Non-emergency transportation  The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. Types of non-emergency transportation include:   * Medicare * Non-emergency ambulance * Service car * Taxicab   [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.] | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Nursing facility (NF) care and skilled nursing facility (SNF) care  The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The plan will pay for the following services and maybe other services not listed here:   * A semi-private room, or a private room if it is medically necessary, maintenance and cleaning * Meals, including special meals, food substitutes, and nutritional supplements * Nursing services and resident supervision/oversight * Physician services * Physical therapy, occupational therapy, and speech therapy * Drugs, and other medications available through a pharmacy without a prescription, ordered by your doctor as part of your plan of care, including over-the-counter medications and their administration * Non-custom durable medical equipment (such as wheelchairs and walkers) * Medical and surgical supply items (such as bandages, oxygen administration supplies, oral care supplies and equipment, one tank of oxygen per resident per month) * Additional services provided by a nursing facility in compliance with state and federal requirements   **This benefit is continued on the next page** | When your income exceeds an allowable amount, you must contribute toward the cost of services. This is known as the patient pay amount and is required if you live in a nursing facility. However, you may not end up having to pay an amount each month.  Patient pay responsibility does not apply to Medicare-covered days in a nursing facility. |
|  | Nursing facility (NF) care and skilled nursing facility (SNF) care (continued)  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 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. |  |
| Red apple appears on the left side of the table next to preventive services | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, the plan will cover counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | 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.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services  The plan will cover the following services, and maybe other services not listed here:   * X-rays * Radiation (radium and isotope) therapy, including technician materials and supplies * Lab tests * Blood, blood components and administration thereof * Other outpatient diagnostic tests   [Plans can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will cover the following services, and maybe other services not listed here:   * 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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf)   This benefit is continued on the next page | $0  [List copays for additional benefits.] |
|  | Outpatient hospital services (continued)   * Labs and diagnostic tests billed by the hospital * Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it * X-rays and other radiology services billed by the hospital * Medical supplies, such as splints and casts * Preventive screenings and preventive services listed throughout the Benefits Chart * Some drugs that you can’t give yourself   [List any additional benefits offered.] |  |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will cover mental health services provided by:   * a state-licensed psychiatrist or doctor, * a clinical psychologist, * a clinical social worker, * a clinical nurse specialist, * a nurse practitioner, * a physician assistant, * a licensed clinical professional counselor, * Community Mental Health Centers (CMHCs), * Behavioral Health Clinics (BHCs), * Hospitals, * Encounter rate clinics such as Federally Qualified Health Centers (FQHCs), **or** * any other Medicare-qualified mental health care professional as allowed under applicable state laws.   This benefit is continued on the next page | $0  [List copays for additional benefits.] |
|  | Outpatient mental health care (continued)  The plan will cover the following types of outpatient mental health services:   * Clinic services provided under the direction of a physician * Rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as Integrated Assessment and Treatment Planning, crisis intervention, therapy, and case management * Day treatment services * Outpatient hospital services, such as Clinic Option Type A and Type B services   The specific services each provider type listed above can deliver and any utilization controls on such services shall be determined by the plan consistent with federal and state laws and all applicable policies and/or agreements. |  |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient mental health crisis services (expanded)  In addition to crisis intervention services, the plan will cover the following medically necessary crisis services:   * Mobile Crisis Response (MCR): MCR is a mobile, time-limited service for crisis symptom reduction, stabilization, and restoration to the previous level of functioning.   MCR services require a face-to-face screening using a state approved crisis-screening instrument and may include: short-term intervention, crisis safety planning, brief counseling, consultation with other qualified providers, and referral to other mental health community services.  To access MCR services, health plan members or individuals concerned about health plan members should call the state’s crisis intake line, CARES, at 1-800-345-9049 (TTY: 1-866-794-0374). CARES will dispatch a local provider to the location of the health plan member in crisis.   * Crisis Stabilization: Crisis stabilization services are time-limited, intensive supports available for up to 30 days following an MCR event to prevent additional behavioral health crises. Crisis stabilization services provide strengths-based support on a one-on-one basis in the home or community.   The health plan will cover Mobile Crisis Response and Crisis Stabilization services provided by:   * Community Mental Health Centers with a crisis certification from the state, or * Behavioral Health Clinics with a crisis certification from the state. | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan will cover 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. | $0 |
|  | Outpatient surgery  The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Partial hospitalization services  Partial hospitalization is a structured program of active psychiatric 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. It can help keep you from having to stay in the hospital.  [Network plans that do not have an in-network community mental health center may add: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | Physician/provider services, including doctor’s office visits  The plan will cover the following services:   * Medically necessary health care or surgery services given in places such as: * physician’s office * certified ambulatory surgical center * hospital outpatient department * Consultation, diagnosis, and treatment by a specialist * Basic hearing and balance exams given by your [insert as applicable: primary care provider **or** specialist], if your doctor orders them to find out whether you need treatment   **This benefit is continued on the next page** | $0  [List copays for additional benefits.] |
|  | Physician/provider services, including doctor’s office visits (continued)   * [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] * 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   **This benefit is continued on the next page** |  |
|  | Physician/provider services, including doctor’s office visits (continued)   * Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:   + 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 * 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 will cover the following services:   * Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) * Routine foot care for members with conditions affecting the legs, such as diabetes   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Prostate cancer screening exams  The plan will cover a digital rectal exam and a prostate specific antigen (PSA) test once every 12 months for:   * Men age 50 and older * African American men age 40 and older * Men age 40 and older with a family history of prostate cancer   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Prosthetic devices and related supplies  Prosthetic devices replace all or part of a body part or function. The plan will cover the following prosthetic devices, and maybe other devices not listed here:   * 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)   The plan will also cover some supplies related to prosthetic devices. They will also pay to repair or replace 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. | $0 |
|  | Pulmonary rehabilitation services  The plan will cover pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have [insert as appropriate: a referral **or** an order] for pulmonary rehabilitation from the doctor or provider treating the COPD.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Red apple appears on the left side of the table next to preventive services | Sexually transmitted infections (STIs) screening and counseling  The plan will cover screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.  The plan will also cover up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will cover these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office.  [Also list any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Substance abuse services  The plan will cover substance abuse services provided by:   * A state-licensed substance abuse facility or * Hospitals.   The plan will cover the following types of medically necessary substance abuse services:   * Outpatient services (group or individual), such as assessment, therapy, medication monitoring, and psychiatric evaluation, * Medication Assisted Treatment (MAT) for opioid dependency, such as ordering and administering methadone, managing the care plan, and coordinating other substance use disorder services, * Intensive outpatient services (group or individual), * Detoxification services, and * Some residential services, such as short-term Rehabilitation Services. | $0  [List copays for additional benefits.] |
|  | **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 | $0 |
|  | 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.  [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.] | $0 |
| Apple icon indicates preventive services. | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  The plan covers the following:   * Annual routine eye exams   + Eye glasses (lenses and frames)   + Frames limited to one pair in a 24 month period * Lenses limited to one pair in a 24 month period, but you may get more when medically necessary, with prior approval [*plans should insert other language describing the plan’s policy*] * Custom-made artificial eye * Low vision devices * Contacts and special lenses when medically necessary, with prior approval [*plans should insert other language describing the plan’s policy*]   To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria.  The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.  **This benefit is continued on the next page** | $0  [List copays for additional benefits.] |
|  | Vision care (continued)  For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include:   * people with a family history of glaucoma, * people with diabetes, * African-Americans who are age 50 and older, **and** * Hispanic Americans who are 65 or older.   [Plans should modify this description if the plan offers more than is covered by Medicare.] The plan covers 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.)  [Also list any additional benefits offered, such as supplemental vision exams or glasses.] |  |
| Red apple appears on the left side of the table next to preventive services | “Welcome to Medicare” Preventive Visit  The plan covers the one-time “Welcome to Medicare” preventive visit. The 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.   **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

| Home and community-based services that our plan covers | | **What you must pay** |
| --- | --- | --- |
|  | Adult day service  The plan covers structured day activities at a program of direct care and supervision if you qualify. This service:   * Provides personal attention * Promotes social, physical and emotional well-being | $0 | |
|  | Assisted living  If you qualify, the Supportive Living Facility provides an alternative to Nursing Facility placement. Some of the services include the following:   * Assistance with activities of daily living * Nursing services * Personal care * Medication administration * Housekeeping * 24 hour response/security staff | $0 | |
|  | Habilitation – day  The plan covers day habilitation, which assists with the retention or improvement in self help, socialization and adaptive skills outside the home if you qualify. | $0 | |
|  | Home delivered meals  The plan covers prepared meals brought to your home if you qualify. | $0 | |
|  | Home health aide  The plan covers services from a home health aide, under the supervision of a registered nurse (RN) or other professional, if you qualify. Services may include the following:   * Simple dressing changes * Assistance with medications * Activities to support skilled therapies * Routine care of prosthetic and orthotic devices | $0 | |
|  | Home modifications  The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:   * Ramps * Grab-bars * Doorway widening | $0 | |
|  | Homemaker services  The plan covers home care services provided in your home or community if you qualify. These services may include the following:   * A worker to help you with laundry * A worker to help you with cleaning * Training to improve your community living skills | $0 | |
|  | Nursing services  The plan covers shift and intermittent nursing services by a registered nurse (RN) or licensed practical nurse (LPN) if you qualify. | $0 | |
|  | Personal assistant  The plan covers a personal assistant to help you with activities of daily living if you qualify. These include, for example:   * Bathing * Feeding * Dressing * Laundry | $0 | |
|  | Personal emergency response system  The plan covers an electronic in home device that secures help in an emergency if you qualify. | $0 | |
|  | Respite care  The plan covers respite services to provide relief for an unpaid family member or primary caregiver who meet all of your service needs if you qualify. Certain limitations apply. | $0 | |
|  | Specialized durable medical equipment and supplies  If you qualify, the plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include:   * Hoyer lift * Shower benches/chairs * Stair lift * Bed rails | $0 | |
|  | Therapies  The plan covers occupational, physical, and speech therapy if you qualify. These therapies focus on long term habilitative needs rather than short term acute restorative needs. | $0 | |

# Our plan’s visitor or traveler benefits

[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, we usually must drop 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. This program is available to all <plan name> members who are in a visitor/traveler area. 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>

[*Plans should modify this section to include additional benefits covered outside the plan by Medicare fee-for-service and/or Medicaid fee-for-service, as appropriate*.]

The following services are not covered by <plan name> but are available through Medicare [*insert if appropriate*: or Medicaid].

## F1. Hospice care

You can get care from any hospice program certified by Medicare. 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. 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 (except for emergency care or urgently needed care):**

* 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 coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

# 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. 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 pays for it.
* A private room in a hospital, except when it is medically necessary.
* Private duty nurses.
* Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
* Full-time nursing care in your home.
* [Plans should delete this if State allows for this:] Fees charged by your immediate relatives or members of your household.
* 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.
* [Plans should delete this if dental services are supplemental benefits:] Preventive dental care. Refer to the Dental services topic for more information on dental coverage.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* [Plans should delete this if supplemental:] Radial keratotomy and LASIK surgery.
* Reversal of sterilization procedures.
* Naturopath services (the use of natural or alternative treatments).
* Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.