Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. 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 this *Evidence of Coverage*.

[*Plans should refer to other parts of the Evidence of Coverage using the appropriate chapter number and section. For example, "refer to* ***Chapter 9****,* ***Section A****." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Evidence of Coverage. Plans can always include additional references to other sections, chapters, and/or member materials when helpful to the reader*.]

[*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 about services our plan covers. You can also learn about services that are’nt covered. Information about drug benefits is in **Chapter 5** of his *Evidence of Coverage*. [*Insert if applicable*: This chapter also explains limits on some services.]

Because you get assistance from NJ FamilyCare, you pay nothing for your covered services as long as you follow our plan’s rules. Refer to **Chapter 3** of this *Evidence of Coverage* for details about the plan’s rules.

If you need help understanding what services are covered, call [*insert*: your Care Manager and/or Member Services at <phone number(s)>].

# Rules against providers charging you for services

We don’t allow our providers to bill you for in network 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** of this *Evidence of Coverage* or call Member Services.

# About our plan’s Benefits Chart

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

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. [*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 pay for the services listed in the Benefits Chart when the following rules are met.** You don’t pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

* We provide covered Medicare and NJ FamilyCare covered services according to the rules set by Medicare and NJ FamilyCare.
* The services (including medical care, behavioral health and substance use disorder treatment services, Managed Long Term Services and Supports (MLTSS), supplies, equipment, and drugs) must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need 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 facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. [*Plans can revise and use the state-specific definition of “medically necessary” and ensure that it’'s updated and used consistently in* ***Chapter 12*** *and throughout member materials.*]
* For new enrollees, for the first 90 days we may not require you you to get approval in advancefor any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
* You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider woln’t be covered unless it‘s an emergency or urgently needed care or unless your plan or a network provider gaveyou a referral. **Chapter 3** of this *Evidence of Coverage* has more information about using network and out-of-network providers.
* You have a primary care provider (PCP) or a care team providing and managing your care. [*Plans that don’t require referrals should omit the rest of the paragraph*: In most cases, your PCP must give you approval before you can use a provider that isn’t your PCP or use other providers in our plan’s network. This is called a referral. **Chapter 3** of this *Evidence of Coverage* has more information about getting a referral and when you **don’t** need one.]
* [*Plans can add information about any continuity of care requirements as directed by the state*.]
* [*Insert if applicable*: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA [*insert as appropriate*: with an asterisk (\*) ***or*** with a footnote ***or*** in bold type **or** in italic type].] [*Insert if applicable*: In addition, you must get PA for the following services not listed in the Benefits Chart: <*insert list>*.]]
* [*Insert if applicable*: If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider’s recommendations.]

[*Insert if offering “Special Supplemental Benefits for the Chronically Ill (SSBCI)”:* **Important Benefit Information for Members with Certain Chronic Conditions.**

* If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for additional benefits:
  + [*List all applicable chronic conditions here*.]
  + [*Include information about the process and/or criteria for determining eligibility for SSBCI.*]
* Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.
* Contact us for additional information.]

[*Insert as applicable*: Most **or** All] preventive services are free. This apple Apple icon represents preventive services in the benefits chart. shows the preventive services in the Benefits Chart.

[*Insert any additional applicable Medicaid program coverage here such as community supports.*]

[*Instructions on completing the Benefits Chart*:

* *For all preventive care and screening test benefit information, plans that cover a richer benefit don’t need to include the given description (unless it is still applicable) and can instead describe the plan benefit.*
* *Optional supplemental benefits aren’t permitted in this chart; optional supplemental benefits should be described in* ***Section E****.*
* *Include the following where appropriate: Talk to your provider and get a referral.*
* *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
* *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit.*
* *Plans should clearly indicate which benefits are subject to PA. (This can be done with asterisks, footnotes, bold type, or italic type. Plans must 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 can insert any additional benefit information that‘s based on the plan’s approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically*.
* *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered*.
* *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member’s access to services within the chart.*
* *Plans can 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 doesn’t resemble any exclusion, then the plan shouldn’t reference the exclusion list.*
* *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
* *Plans with no cost-sharing for any type of service (i.e., no cost-sharing at all) may delete the “what you must pay” column from the table. Plans with any type of cost-sharing for services, including for pharmacy services, must leave the “what you must pay” column in the table.*
* *Plans offering targeted supplemental benefits in Section B-19 of the Plan Benefit Package submission must:*
* *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the “Uniformity Flexibility” benefits for which they‘re eligible*.]

# Our plan’s 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 benefits 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*.]

[*Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid. Plans may include any requirements or specific benefits in the right column*.]

| Covered Service | | What you pay and any additional requirements |
| --- | --- | --- |
| Apple indicates preventive benefit. | Abdominal aortic aneurysm screening  We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.  [*List any additional benefits offered*.] | $0 |
|  | Acupuncture  We pay for acupuncture visits 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.   Acupuncture treatments must be stopped if you don’t get better or if you get worse.  Provider Requirements:  Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.  Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:   * a master’s or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, * a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.   Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Alcohol misuse screening and counseling  We pay for one alcohol-misuse screening for adults who misuse alcohol but aren’t alcohol dependent. This includes pregnant women.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you ‘re able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.  [*List any additional benefits offered*.] | $0 |
|  | Ambulance services  Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and 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 life.  Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren’t emergencies, we 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 |
| Apple icon indicates preventive services. | Annual wellness visit  You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.  **Note:** Your first annual wellness visit can’t take place within 12 months of your **Welcome to Medicare** visit. However, you don’t need to have had a **Wecome to Medicare** visit to get annual wellness visits after you’ve had Part B for 12 months.  [*List any additional benefits offered*.] | $0 |
|  | Autism Spectrum Disorder Services  For all members with an Autism Spectrum Disorder (ASD) diagnosis, we pay for:   * Applied Behavioral Analysis (ABA) * augmentative and alternative communication services and devices * Sensory Integration (SI) services * allied health services (physical therapy, occupational therapy and speech therapy) * Developmental, Individual-differences, and Relationship-based (DIR) services, including but not limited to DIR Floortime and the Greenspan approach therapy | $0 |
| Apple icon indicates preventive services. | Bone mass measurement  We pay for 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.  We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Breast cancer screening (mammograms)  We pay for the following services:   * one baseline mammogram between the ages of 35 and 39 [*plans that only cover ages 65 and over should delete*] * one screening mammogram every 12 months [*plans that cover women under 65 should include*: for women aged 40 and over] * clinical breast exams once every 12 months   [*List any additional benefits offered*.] | $0 |
|  | Cardiac (heart) rehabilitation services  We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor’s [*insert as appropriate*: referral ***or*** order].  We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the [visit ***or*** visits], your doctor may:   * discuss aspirin use, * check your blood pressure, **and/or** * give you tips to make sure you are eating well.   [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease screening tests  We pay for blood tests to check for cardiovascular disease annually for all members 20 years of age or older, and more frequently if medically necessary. These blood tests also check for defects due to high risk of heart disease.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Cervical and vaginal cancer screening  We pay for the following services:   * for all women: Pap tests and pelvic exams once every 12 months   [*List any additional benefits offered*.] | $0 |
|  | Chiropractic services  We pay for the following services:   * adjustments of the spine to correct alignment * clinical laboratory services * certain medical supplies * durable medical equipment * prefabricated orthoses * physical therapy services * diagnostic radiological services when they are prescribed by a chiropractor within their scope of practice   [*List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits*.] | $0 |
|  | Chronic pain management and treatment services  Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. |  |
| Apple icon indicates preventive services. | Colorectal cancer screening  We 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 aren’t at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. * Computed tomography colonography for patients 45 years and older who aren’t at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. * Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or 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.   **This benefit is continued on the next page** | $0 |
|  | Colorectal cancer screening (continued)   * 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. * Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result.   [*List any additional benefits offered*.] |  |
|  | [*Include row if applicable and modify to accurately describe the Medicaid and/or supplemental benefit offered*.]  Dental services  This benefit includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services.  We pay for dental examinations, cleanings, fluoride treatment and any necessary x-rays. We pay for this service twice per rolling year. Examples of covered services include (but are not limited to):   * oral evaluations (examinations) * x-rays and other diagnostic imaging * dental cleaning (prophylaxis) * topical fluoride treatments * fillings * crowns * root canal therapy * scaling and root planing * complete and partial dentures * oral surgical procedures (to include extractions) * intravenous anesthesia/sedation (where medically necessary for oral surgical procedures)   Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs.  **This benefit is continued on the next page** | $0 |
|  | Dental services (continued)  Some procedures may require prior authorization with documentation of medical necessity, including:   * Orthodontic services for members up to age 21 with adequate documentation of a handicapping malocclusion or medical necessity. * Dental treatment in an operating room or ambulatory surgical center.   We pay for some dental services when the service is an integral part of specific treatment of a person’s primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. | $0 |
| Apple icon indicates preventive services. | Depression screening  We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Diabetes screening  We pay for 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’re overweight and have a family history of diabetes.  You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Diabetic self-management training, services, and supplies  We pay for 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, we pay for the following: * one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** * one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) * In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.   [*List any additional benefits offered*.] | $0 |
|  | Doula Services  We pay for the services of a doula. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula doesn’t replace a licensed medical professional, andcan’tperformclinical tasks. | $0 |
|  | Durable medical equipment (DME) and related supplies  Refer to **Chapter 12** of this *Evidence of Coverage* for a definition of “Durable medical equipment (DME).”  We cover the following items:   * wheelchairs * crutches * powered mattress systems * diabetic supplies * hospital beds ordered by a provider for use in the home * intravenous (IV) infusion pumps and pole * speech generating devices * oxygen equipment and supplies * nebulizers * walkers * standard curved handle or quad cane and replacement supplies * cervical traction (over the door) * bone stimulator * dialysis care equipment   Other items may be covered.  **This benefit is continued on the next page** | $0 |
|  | Durable medical equipment (DME) and related supplies (continued)  [*Plans that don’t limit the DME brands and manufacturers that they cover, insert*:We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn’t 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 they cover, insert the following (for more information about this requirement, refer to* ***Chapter 4*** *of the Medicare Managed Care Manual*): With this *Evidence of Coverage*, we sent you our plan’s list of DME. The list tells you the brands and makers of DME that we pay for. You can also find the most recent list of brands, makers, and suppliers on our website at <URL>.  Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We don’t cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you‘re new to our plan and using a brand of DME not on our list, we’ll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 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) don’t agree with our plan’s coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don’t agree with your doctor’s decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to **Chapter 9** of this *Evidence of Coverage*.] | $0 |
|  | Early and Periodic Screening Diagnosis and Treatment (EPSDT)  For members under 21 years of age, we pay for the following services:   * well child care * preventive screenings * medical examinations * vision and hearing screenings and services * immunizations * lead screening * private duty nursing services   We pay for private duty nursing for eligible EPSDT members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. | $0 |
|  | Emergency care  Emergency care means services that are:   * given by a provider trained to give emergency services, **and** * needed to evaluate or treat a medical emergency.   A medical emergency is an illness, injury, sever pain, or medical condition that’s quickly getting worse. 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 lifeor to that of your unborn child; **or** * serious harm to bodily functions; **or** * loss of a limb, or loss of function of a limb. * In the case of a pregnant woman in active labor, when: * There isn’t 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 move 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 our plan approves your stay.)]. |
|  | [*If family planning services are covered, plans should modify this as necessary*.]  Family planning services  The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.  We pay for the following services:   * family planning exam and medical treatment * family planning lab and diagnostic tests * family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) * family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) * counseling and diagnosis of infertility and related services * counseling, testing, and treatment for sexually transmitted infections (STIs) * counseling and testing for HIV and AIDS, and other HIV-related conditions * permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) * genetic counseling   **This benefit is continued on the next page** | $0 |
|  | Family planning services (continued)  We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:   * treatment for medical conditions of infertility (This service doesn’t include artificial ways to become pregnant.) * treatment for AIDS and other HIV-related conditions * genetic testing   Services furnished by out-of-network providers are paid for directly by Medicaid. |  |
| Apple icon indicates preventive services. | 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*.]  [*If this benefit isn’t applicable, plans should delete this row*.] | $0 |
|  | [*Plans should modify this section to reflect plan-covered benefits as appropriate*.]  Hearing services  We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They‘re covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  We pay for the following services:   * routine hearing exams * diagnostic hearing exams and balance exams * otologic and hearing aid examinations prior to prescribing hearing aids * hearing aids, as well as associated accessories and supplies * exams for the purpose of fitting hearing aids * follow-up exams and adjustments * repairs after warranty expiration | $0 |
|  | [*If this benefit isn’t 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*.] | $0 |
| Apple icon indicates preventive services. | HIV screening  We pay 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.   If you are pregnant, we pay for up to three HIV screening tests during a pregnancy.  [*List any additional benefits offered*.] | $0 |
|  | 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. You must be homebound, which means leaving home is a major effort.  We pay for the following services, and maybe other services not listed here:   * part-time or intermittent skilled nursing and home health aide services * physical therapy, occupational therapy, and speech therapy * medical and social services * medical equipment and supplies | $0 |
|  | Home infusion therapy  Our plan pays 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.   Our plan covers home infusion services that include but aren’t 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*.] | $0 |
|  | 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. Our plan must help you find Medicare-certified hospice programs in the plan’s service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.  Covered services include:   * drugs to treat symptoms and pain * short-term respite care * home care   The plan also covers certain durable medical equipment, as well as spiritual and grief counseling. For members under 21 years of age, both palliative and curative care are covered.  **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.**   * Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you’re in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for.   **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:**   * Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services.   **This benefit is continued on the next page** | $0 |
|  | Hospice care (continued)  **For drugs that may be covered by our plan’s Medicare Part D benefit:**   * Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Evidence of Coverage*.   **Note:** If you need non-hospice care, call your Care Manager and/or Member Services to arrange the services. Non-hospice care is care that **isnt** related to your terminal prognosis. Our plan covers all of your medical care not related to your terminal prognosis as it normally would.  [*Insert if applicable, edit as appropriate*: Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn’t chosen the hospice benefit.] | $0 |
|  | Housing Supports  The Housing Supports program is a set of housing services intended to ensure that members can live in a safe, healthy, and affordable home.  Housing Supports consists of four services:   * Pre-tenancy Services (case management) * Tenancy Sustaining Services (case management) * Move-in Supports * Residential Modification and Remediation Services   To be eligible for Housing Supports, a member must:   * Meet at least one social-risk criterion (including, but not limited to: homelessness; at-risk of homelessness; transitioning from an institution; recently released from a correctional facility) * Meet at least one clinical-risk criterion (including, but not limited to: a chronic health condition; a mental health condition; substance misuse; pregnancy; complex medical health due to disability; sexual/domestic violence; assisted living needs; repeated hospitalization)   Please contact your Care Manager or call the Member Services number at the bottom of this page for more information. | $0 |
| Apple icon indicates preventive services. | Immunizations  We pay for the following services:   * pneumonia vaccines * flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary * hepatitis B vaccines if you‘re at high or intermediate risk of getting hepatitis B * COVID-19 vaccines * other vaccines if you‘re at risk and they meet Medicare Part B coverage rules   The full childhood immunization schedule is covered for members under the age of 21.  We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Evidence of Coverage* to learn more.  [*List any additional benefits offered*.] | $0 |
|  | Inpatient hospital care  Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you’re formally admitted to the hospital with a doctor’s order. The day before you’re discharged is your last inpatient day.  [*List any restrictions that apply*.]  We pay for the following services and other medically necessary services not listed here:   * semi-private room (or a private room if medically necessary) * meals, including special diets * regular nursing services * costs of special care units, such as intensive care or coronary care units * drugs and medications * lab tests * X-rays and other radiology services * needed surgical and medical supplies * appliances, such as wheelchairs * operating and recovery room services * physical, occupational, and speech therapy * inpatient substance abuse disorder treatment services * in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral   **This benefit is continued on the next page** | $0 |
|  | Inpatient hospital care (continued)  If you need a transplant, a Medicare-approved transplant center will review your case and decide if you‘re 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 our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [*Plans may further define the specifics of transplant travel coverage*.]   * blood, including storage and administration * physician services   **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you’re not sure if you’re an inpatient or an outpatient, ask the hospital staff.  Get more information in the Medicare fact sheet *Medicare Hospital Benefits* This fact sheet is available at [Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. | $0 |
|  | Inpatient services in a psychiatric hospital  We pay for mental health care services that require a hospital stay. We pay for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment.  The plan covers the following services:   * inpatient services in a psychiatric hospital * services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital * Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting)   [*List any additional benefits offered*.] | $0 |
|  | Kidney disease services and supplies  We pay for the following services:   * Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We 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** of this *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible. * Inpatient dialysis treatments if you’re admitted as an inpatient to a hospital for special care * Self-dialysis training, 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.   Medicare Part B pays for some drugs for dialysis. For information, refer to “Medicare Part B drugs” in this chart. | $0 |
| Apple icon indicates preventive services. | Lung cancer screening with low dose computed tomography (LDCT)  Our plan pays 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, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.  [*Modify section to accurately describe benefits and list any additional benefits offered*.] | $0 |
|  | Managed Long Term Services and Supports (MLTSS)  The MLTSS program provides Home-and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting.  This MLTSS program is available to members who meet certain clinical and financial requirements.  MLTSS services include (but aren’t limited to):   * assisted living services * cognitive, speech, occupational, and physical therapy * chore services * home-delivered meals * residential modifications (such as the installation of ramps or grab bars) * vehicle modifications * social adult day care * non-medical transportation | $0 |
|  | Medical Day Care  This benefit is for people with physical and/or cognitive impairments.  Our plan pays for preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. | $0 |
| Apple icon indicates preventive services. | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It’s also for after a kidney transplant when [*insert as appropriate*: referred ***or***ordered] by your doctor.  We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.  We pay for 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 you need treatment in the next calendar year. We may approve additional services if medically necessary.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Medicare Diabetes Prevention Program (MDPP)  Our plan pays for MDPP services for eligible people. 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 drugs  [*Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).*]  These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:   * drugs you don’t usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services * insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) * the Alzheimer’s drug Leqembi® (generic lecanemab) which is given intravenously (IV). * other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized * clotting factors you give yourself by injection if you have hemophilia * transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn’t cover them~~,~~ * osteoporosis drugs that are injected. We pay for these drugs if you’re homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can’t inject the drug yourself   **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B drugs (continued)**   * some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision * certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does * oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug * certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B * calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar * certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), and topical anesthetics, * erythropoiesis-stimulating agents: Medicare covers erthropoietin by injection if you have ESRD or you need this drugh to treat anemia related to cetain other conditions [*plans may delete any of the following drugs that they don’t cover*] (such as Epogen®, Procrit®, Retacrit ®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, MIcrera®, or Methoxy polyethylene glycol-epotin beta)   **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B drugs (continued)**   * IV immune globulin for the home treatment of primary immune deficiency diseases * parenteral and enteral nutrition (IV and tube feeding)   [*Insert if applicable*: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: <URL>.]  We also cover some vaccines under our Medicare Part B and most adult vaccines undr our Medicare Part D drug benefit.  **Chapter 5** of this *Evidence of Coverage* explains our drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 of this *Evidence of Coverage* gives more information about the *Explanation of Benefits (*EOB) and how it helps you track your drug coverage. |  |
|  | Nursing facility care  A nursing facility (NF) is a place that provides care for people who can’t get care at home but who don’t need to be in a hospital.  Services that we pay for include, but aren’t limited to, the following:   * semiprivate room (or a private room if medically necessary) * meals, including special diets * nursing services * physical therapy, occupational therapy, and speech therapy * respiratory therapy * drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) * blood, including storage and administration * medical and surgical supplies usually given by nursing facilities * lab tests usually given by nursing facilities * X-rays and other radiology services usually given by nursing facilities * use of appliances, such as wheelchairs usually given by nursing facilities * physician/practitioner services * durable medical equipment * dental services, including dentures * vision benefits   **This benefit is continued on the next page** | $0 |
|  | Nursing facility care (continued)   * hearing exams * chiropractic care * podiatry services   You 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 facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). * a nursing facility where your spouse or domestic partner is living at the time you leave the hospital. | $0 |
|  | **Nutrition Supports Program**  The nutrition supports program is intended to help members in MLTSS assess their dietary needs and nutritional options, and also includes services to provide pantry items and/or groceries to members under certain circumstances to ensure they have adequate access to food.  The plan will conduct an assessment to determine eligibility for the benefit.  **Nutrition Counseling and Education:**  Nutrition counseling and education assesses a member’s dietary intake, identifies areas where changes are needed, and provides individualized advice an guidance about options and methods for improving nutritional status. Strategies can be provided in individual or group settings and are meant to motivate and facilitate food choices, meal preparation, and other food and nutrition-related behaviors conducive to health and wellbeing.  To be eligible for nutrition counseling and education, a member must be enrolled in MLTS and experiencing a significant or emergent disruption in their ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement.  **Transitional Pantry Stocking**  The one-time purchase of essential pantry stocking items to ensure adequate and necessary access to food and goods immediately following transition from an institutional setting. This may include variou foods, ingredients, baking supplies, and certain household items.  To be eligible for transitional pantry stocking, a member must be enolled in MLTSS and meet the following risk factors:  **Continued on the next page** |  |
|  | **Nutrition Supports Program (continued)**   * Meet the USDA definition of either low or very low food security; * Transitioning to a community residence from an institutional setting, such as a certified nursing home, mental health facility, acute care hospital with an extended stay (30 days or more); carceral settings (for example, state prison, county correctional facility); and * Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence.   Short-Term Grocery Provision:  The provision of short-term groceries purchased and delivered from a food retailer, for an MLTSS beneficiary who meets eligibility requirements.  To be eligible for Short-Term Grocery Provision, a member must be enrolled in MLTSS and:   * Meet the USDA definition of either low or very low food security; * Be experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement.   Please contact your Care Manager or call the Member Services number at the bottom of this page for more information. |  |
| Apple icon indicates preventive services. | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, we pay for 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 |
|  | Opioid treatment program (OTP) services  Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services:   * intake activities * periodic assessments * medications approved by the 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 other medically necessary treatment or additional benefits offered, with the exception of meals and transportation*.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  We pay for the following services and other medically necessary services not listed here:   * X-rays * radiation (radium and isotope) therapy, including technician materials and supplies * surgical supplies, such as dressings * splints, casts, and other devices used for fractures and dislocations * lab tests * blood, including storage and administration * diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition * other outpatient diagnostic tests   [*Plans can include other covered tests as appropriate*.] | $0 |
|  | Outpatient hospital observation  We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged.  The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.  Note: Unles the provider has written an order to admit you as an inpatient to the hospital, you’re an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren’t sure if you’re an outpatient, ask hospital staff.  Get more information in the Medicare fact sheet *Medicare Hospital Benefts.* This fact sheet is available at [Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) |  |
|  | Outpatient hospital services  We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:   * 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 “inpatient.” * Sometimes you can be in the hospital overnight and still be “outpatient.” * You can get more information about being inpatient or outpatient in this fact sheet: [medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) * 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 services listed throughout the Benefits Chart * some drugs that you can’t give yourself   [*List any additional benefits offered*.] | $0 |
|  | [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate*.]  Outpatient mental health care  We pay for 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) * any other Medicare-qualified mental health care professional as allowed under applicable state laws * an Independent Practitioner Network or IPN (psychiatrist, psychologist, or Advanced Practice Nurse (APN))   Additionally, the plan covers the following services:   * adult mental health rehabilitation (supervised group homes and apartments) * mental health outpatient (clinic/hospital services) * partial care and medication management   [*List any additional benefits offered*.] | $0 |
|  | [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate*.]  Outpatient rehabilitation services  We pay for 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 substance use disorder treatment services  We pay for the following services, and maybe other services not listed here:   * alcohol misuse screening and counseling * treatment of drug abuse * group or individual counseling by a qualified clinician * subacute detoxification in a residential addiction program * alcohol and/or drug services in an intensive outpatient treatment center * extended-release Naltrexone (vivitrol) treatment   The plan covers substance use disorder screening, referrals, drugs, and treatment of conditions. Covered services include, but aren’t limited to, the following:   * non-medical detoxification/non-hospital based withdrawal management * substance use disorder short term residential * ambulatory withdrawal management with extended on-site monitoring/ambulatory detoxification * substance use disorder partial care * substance use disorder intensive outpatient * substance use disorder outpatient * opioid treatment services (methadone and non-methadone medication assisted treatment) * Refer to “Opioid treatment program (OTP) services” earlier in this chart for details. * Peer Recovery Support Services (PRSS)   [*Modify this list accurately describe benefits offered or add any additional benefits offered*.] | $0 |
|  | Outpatient surgery  We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.  **Note:** If you’re having surgery in a hospital facility, you should check with your provider about whether you’ll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you’re an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. | $0 |
|  | [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate*.]  Partial hospitalization services and intensive outpatient services  Partial hospitalization is a structured program of active psychiatric treatment. It‘s offered as a hospital outpatient service or by a community mental health center that’s more intense than the care you get in your doctor’s therapist’s, licensed marriage and family therapist’s (LMFT), or licensed professional counselor’s office. It can help keep you from having to stay in the hospital.  **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that’s more intense than care you get in your doctor’s or therapist’s office but less intense than partial hospitalization.  [*Plans that don’t have an in-network community mental health centercan add*: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | **Personal Care Assistance (PCA)**  Covers health related tasks performed by a qualified individual in a member’s home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member’s written plan of care. | $0 |
|  | Physician/provider services, including doctor’s office visits  We pay for 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 * [*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 Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider isn’t in the same location as the member). Plans may refer members to its medical coverage policy here*].   **This benefit is continued on the next page** | $0 |
|  | Physician/provider services, including doctor’s office visits (continued)   * 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 Medicare 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 at 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** | $0 |
|  | Physician/provider services, including doctor’s office visits (continued)   * telehealth services for diagnosis, evaluation, and treatment of mental health disorders * 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 * evaluation of video and/or images you send to your doctor, interpretation, and follow-up by your doctor within 24 hours * 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   [*List any additional benefits offered*.] | $0 |
|  | Podiatry services  We pay for 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 * routine exams   [*List any additional benefits offered*.] | $0 |
|  | Private Duty Nursing (PDN)  This benefit is for eligible members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. It’s covered for MLTSS members of any age. | $0 |
| Apple icon indicates preventive services. | Pre-exposure prophylaxis (PrEP) for HIV prevention  If you don’t have HIV, but your doctor or other health care practitioner determines you’re at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.  If you qualify, covered services include:   * FDA-approved oral or injectable PrEP medication. If you’re getting an injectable drug, we also cover the fee for injecting the drug. * Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. * Up to 8 HIV screenings every 12 months. * A one-time hepatitis B virus screening. |  |
| Apple icon indicates preventive services. | Prostate cancer screening exams  For men aged 50 and over, (and for men 40 and older with a family history of prostate cancer or other risk factors), we pay for the following services once every 12 months:   * a digital rectal exam * a prostate specific antigen (PSA) test   [*List any additional benefits offered*.] | $0 |
|  | [*Plans should modify this section to reflect Medcaid or plan-covered supplemental benefits as appropriate*.]  Prosthetic and orthotic devices and related supplies  Prosthetic devices replace all or part of a body part or function. These include but aren’t limited to:   * testing, fitting, or training in the use of prosthetic and orthotic devices * 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)   We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices.  We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details. | $0 |
|  | Pulmonary rehabilitation services  We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You 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 |
| Apple icon indicates preventive services. | Screening for Hepatitis C Virus infection  We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:   * You’re at high risk because you use or have used illicit injection drugs. * You had a blood transfusion before 1992. * You were born between 1945-1965.   If you were born between 1945-1965 and aren’t considered high risk, we pay for a screening once. If you’re at high risk (for example, you’ve continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings. |  |
| Apple icon indicates preventive services. | Sexually transmitted infections (STIs) screening and counseling  We pay for 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.  We also pay for 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. We pay for these counseling sessions as a preventive service only if 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 |
|  | Short-Term Grocery Provision:  The provision of short-term groceries purchased and delivered from a food retailer, for an MLTSS beneficiary who meets eligibility requirements.  To be eligible for Short-Term Grocery Provision, a member must be enrolled in MLTSS and:   * Meet the USDA definition of either low or very low food security; * Be experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement.   Please contact your Care Manager or call the Member Services number at the bottom of this page for more information. | $0 |
|  | Skilled nursing facility (SNF) care  For a definition of skilled nursing facility care, go to **Chapter 12.**  [*List days covered and any restrictions that apply, including whether any prior hospital stay is required.*]We 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 * meals, including special diets * skilled 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 SNFs * lab tests given by SNFs * X-rays and other radiology services given by nursing facilities * appliances, such as wheelchairs, usually given by nursing facilities * physician/provider services * long term (custodial) care in a nursing facility   You usually get SNF care from network facilities. Under certain conditions 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 facility 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 | $0 |
| Apple icon indicates preventive services. | Smoking and tobacco use cessation  If you use tobacco, don’t have signs or symptoms of tobacco-related disease, and want or need to quit:   * We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.   The plan also covers over-the-counter (OTC) smoking cessation products, including nicotine gums, nicotine lozenges and nicotine patches. | $0 |
|  | Supervised exercise therapy (SET)  We 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].  Our plan pays 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 |
|  | Transitional Pantry Stocking:  The one-time purchase of essential pantry stocking items to ensure adequate and necessary access to food and goods immediately following transition from an institutional setting. This may include various foods, ingredients, baking supplies, and certain household items.  To be eligible for Transitional Pantry Stocking, a member must be enrolled in MLTSS and meet the following risk factors:   * Meet the USDA definition of either low or very low food security; * Transitioning to a community residence from an institutional setting, such as a certified nursing home, mental health facility, acute care hospital with an extended stay (30 days or more); carceral settings (for example, state prison, county correctional facility); and * Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence. |  |
|  | Transportation  Medicaid Fee-for-Service directly covers non-emergency transportation.  Covered services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage).  All non-emergency transportation is arranged through the state’s transportation vendor, Modivcare. To schedule transportation, call Modivcare at 1-866-527-9933. You can also ask your PCP or Care Manager to help you to arrange this service. Please call [*insert*: your Care Manager and/or Member Services at <phone number(s)>]. | $0 |
|  | Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency that requires immediate medical care, **or** * an unforeseen 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 can’t get to a network provider beause given your time, place or circumstances, it‘s not possible, or it’'s unreasonable, to get this service from network providers (for example, when you‘re outside the plan’s service area and you require medically needed immediate services for an unseen condition but it’s 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*.] | $0 |
|  | [*Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services*.]  Vision care  We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye, including a comprehensive eye exam once per year for all members. For example, treatment for age-related macular degeneration.  For people at high risk of glaucoma, we pay for 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 50 and over * Hispanic Americans who are 65 and over   For people with diabetes, we pay for screening for diabetic retinopathy once per year.  For all other members aged 35 and over, a glaucoma screening is covered every five years.  [*Plans should modify this description if the plan offers more than is covered by Medicare*.] We pay for 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 can’t get two pairs of glasses after the second surgery, even if you didn’t get a pair of glasses after the first surgery.  **This benefit is continued on the next page** | $0 |
|  | Vision care (continued)  The plan also covers the following:   * optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses * replacement lenses and frames (or contact lenses) * once every 24 months for people age 19 through 59, **or** * once per year for beneficiaries 18years of age or younger, **or** * once per year for beneficiaries 60 years of age or older | $0 |
| Apple icon indicates preventive services. | “Welcome to Medicare” preventive visit  We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:   * a review of your health, * education and counseling about 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 |

# 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 about getting the out-of-area coverage, including the impact based on Medicaid requirements. 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‘re out of the plan’s service area for more than 6 months at a time but don’t 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 allows you to stay enrolled in our plan when you’re outside of our service area for up to 12 months. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you’re in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don’t return to our plan’s service area by <end date>, we’ll end your membership in our plan.]

# Benefits covered outside of our plan

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

We don’t cover the following services, but they’re available through NJ FamilyCare.

* Non-emergency transportation, including mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and delivery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). These services are paid for directly by Medicaid (also known as Medicaid Fee-for-Service).

# Benefits not covered by our plan, Medicare, or NJ FamilyCare

This section tells you about benefits excluded by our plan. “Excluded” means that we don’t pay for these benefits. Medicare and Medicaid don’t pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don’t pay for excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won’t pay for the services. If you think that our plan should pay for a service that isn’t covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn’t cover the following items and services:

[*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 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 can add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans can also add exclusions as needed*.]

* services considered not “reasonable and medically necessary”, according Medicare and NJ FamilyCare standards, unless we list these as covered services
* experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
* surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
* a private room in a hospital, except when medically necessary
* personal items in your room at a hospital or a nursing facility, such as a telephone or television
* 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’s needed because of an accidental injury or to improve a part of the body that isn’t shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
* chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines, and as described in Chiropractic Services in the Benefits Chart in **Section D**
* routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
* 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
* radial keratotomyand LASIK surgery
* reversal of sterilization procedures and non-prescription contraceptive supplies
* naturopath services (the use of natural or alternative treatments)
* services provided to veterans in Veterans Affairs (VA) facilities