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

Introduction

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

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

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

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

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

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

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment [insert if plan has cost sharing: and your cost sharing amount] as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay [insert as applicable: nothing **or** only your share of the cost] for covered services.

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

<Plan name> covers all services covered by Medicare and Healthy Connections Medicaid. This includes behavioral health and LTSS.

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

* The care you get must be a **plan benefit**. This means that it must be included in the plan’s Benefits Chart. (The chart is in Chapter 4 [plans may insert reference, as applicable] of this handbook).
* The care must be **medically necessary**. Medically necessarymeans that the services are reasonable and necessary:
* For the diagnosis or treatment of your illness or injury; **or**
* To improve the functioning of a malformed body member; **or**
* Otherwise medically necessary under Medicare law.
* In accordance with Healthy Connections Medicaid law and regulation, services must be:
* Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity;
* Provided at an appropriate facility at the appropriate level of care for the treatment of your medical condition; **and**
* Provided in accordance with generally accepted standards of medical practice.
* [Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.] You must have a network **primary care provider (PCP)** who has ordered the care or has told you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
* In most cases, [insert as applicable: your network PCP **or** our plan] 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**. If you don’t get approval, <plan name> may not cover the services. You don’t need a referral to use certain specialists, such as women’s health specialists. To learn more about referrals, refer to page <page number>.
* You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman’s health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page <page number>.
* To learn more about choosing a PCP, refer to page <page number>.
* **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
* The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed caremeans, refer to Section I, page <page number>.
* If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. [Plans may specify whether authorization should be obtained from the plan prior to seeking care.] In this situation, we will cover the care [insert as applicable: as if you got it from a network provider **or** at no cost to you]. To learn about getting approval to use an out-of-network provider, refer to Section D, page<page number>.
* The plan covers kidney dialysis services when you are outside the plan’s service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility. [Insert as applicable: The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan’s service area and obtain the dialysis from a provider that is outside the plan’s network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.]
* When you first join the plan, you can continue using the providers you use now for 180 days or until we have completed your comprehensive assessment and created a transition plan that you agree with. If you need to continue using your out-of-network providers after your first 180 days in our plan, we will only cover that care if the provider enters a single case agreement with us. If you are getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact [plans must enter name of department or entity] at <phone number>.

# Information about your [care coordinator/care manager *(plan’s preference)*]

[Plans should provide applicable information about care coordination, including explanations for the following subsections.]

## C1. What a [care coordinator/care manager *(plan’s preference)*] is

## C2. How you can contact your [care coordinator/care manager *(plan’s preference)*]

## C3. How you can change your [care coordinator/care manager *(plan’s preference)*]

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

## D1. Care from a primary care provider (PCP)

[**Note:** Insert this section only if your plan uses PCPs.]

You [insert as applicable: may **or** must] choose a PCP to provide and manage your care.

Definition of “PCP,” and what the PCP does for you

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

What a PCP is

What types of providers may act as a PCP [If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP.]

The role of a PCP in:

* coordinating covered services
* making decisions about or obtaining prior authorization (PA), if applicable

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

Your choice of PCP

[Plans must describe how to choose a PCP.]

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network. We can help you find a new PCP if the one you have now leaves our network.

[Plans should describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]

Services you can get without first getting approval from your PCP

[**Note:** Insert this section only if plans use PCPs or require referrals to network providers.]

In most cases, you will need approval from your PCP before using other providers. This approval is called a referral.You can get services like the ones listed below without first getting approval from your PCP:

* Emergency services from network providers or out-of-network providers.
* Urgently needed care from network providers.
* Urgently needed care from out-of-network providers when you can’t get to a network provider (for example, when you are outside the plan’s service area or you need immediate care during the weekend).

NOTE: Services must be immediately needed and medically necessary.

* Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan’s service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
* Flu shots and COVID-19 vaccinations [insert if applicable: as well as hepatitis B vaccinations and pneumonia vaccinations] [insert if applicable: as long as you get them from a network provider].
* Routine women’s health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams [insert if applicable: as long as you get them from a network provider].
* Additionally, if you are eligible to get services from Indian health providers, you may use these providers without a referral.

[Plans should add additional bullets consistently formatted like the rest of this section as appropriate.]

## D2. Care from specialists and other network providers

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

* Oncologists care for patients with cancer.
* Cardiologists care for patients with heart problems.
* Orthopedists care for patients with bone, joint, or muscle problems.

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

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

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

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

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

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

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

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

* Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
* We will notify you that your provider is leaving our plan so that you have time to select a new provider.
* If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
* If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
* We will help you select a new qualified in-network provider to continue managing your health care needs.
* If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask for, and we will work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
* We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
* If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. [Plans should indicate if prior authorization is needed.]
* If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make an appeal of our decision. Refer to Chapter 9 [plans may insert a reference, as applicable] for information about making an appeal.

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

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

[HMO plans that are **not** HMO POS, tell members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Healthy Connections Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.]

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

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

# How to get behavioral health services

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

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

Long-term services and supports (LTSS) help meet your daily needs for assistance and help improve the quality of your life. LTSS can help you with everyday tasks like taking a bath, getting dressed, and making food. Most of these services are provided in your home or in your community, but they could also be provided in a nursing home or hospital.

LTSS are available to members who are on certain waiver programs operated by the Community Long Term Care (CLTC) division of Healthy Connections Medicaid. Those waivers are:

* Community Choices waiver
* HIV/AIDS waiver
* Mechanical Ventilator Dependent waiver

Members on different waivers can get different kinds and amounts of LTSS. If you think you need LTSS, you can talk to your [care coordinator/care manager (plan’s preference)] about how to access them and whether you can join one of these waivers. Your [care coordinator/care manager (plan’s preference)] can give you information about how to apply for an appropriate waiver and all of the resources available to you under the plan.

Refer to the *Provider and Pharmacy Directory* for more information about these programs.

[Plans should provide applicable information about getting LTSS if a member is not a waiver participant.]

# G. [If applicable plans should add: How to get self-directed care]

[Plans should provide applicable information about getting self-directed care, including the following subsections.]

## G1. What self-directed care is

## G2. Who can get self-directed care (Note: This is limited to waiver populations, per the Plan Benefit Package.)

## G3. How to get help in employing personal care providers (if applicable)

# How to get transportation services

[Plans should provide applicable information about getting transportation services.]

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

## I1. Care when you have a medical emergency

Definition of a medical emergency

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

* serious risk to your health; **or**
* serious harm to bodily functions; **or**
* serious dysfunction of any bodily organ or part.

What to do if you have a medical emergency

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories [Insert as applicable: or worldwide] from any provider with an appropriate state license.
* [Plans add if applicable: **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else [plans may replace “someone else” with “your [care coordinator*/*care manager *(plan’s preference)*]” or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us.] [Plans must either provide the phone number and days and hours of operation or explain where to find the number (e.g., at the bottom of the page, on the back of <plan name>’s Member ID Card).]

Covered services in a medical emergency

[Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

[Plans may modify this paragraph as needed to address their post-stabilization care.] Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What to do if you have a behavioral health emergency

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

Getting emergency care if it wasn’t an emergency after all

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

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

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

## I2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

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

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

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

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

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

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

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

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

[Plans with world-wide emergency/urgent coverage as a supplemental benefit, modify this section.]

## I3. Care during a disaster

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

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

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

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

[Plans with an arrangement with the State may add language to reflect that the organization is not allowed to reimburse members for Healthy Connections Medicaid-covered benefits. If members overpay for these benefits, they need to seek reimbursement from the provider instead.]

**Do not pay directly for services that Healthy Connections Medicaid covers.**

If a provider sends you a bill instead of sending it to our plan, you can ask us to pay [plans with cost sharing, insert: our share of] the bill.

If you pay the provider, we can’t pay you back, but the provider will.Member Services or the Healthy Connections Prime Advocate can help you contact the provider’s office. Refer to the bottom of the page and Chapter 2 [plans may insert reference, as applicable] for their phone numbers.

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

[Insert as applicable: If you have paid for your covered services **or** If you have paid more than your share for covered services] or if you have gotten a bill for [plans with cost sharing, insert: the full cost of] covered medical services, refer to Chapter 7 [plans may insert reference, as applicable] to learn what to do.

## J1. What to do if services are not covered by our plan

<Plan name> covers all services:

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

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

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

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

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

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

## K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

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

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

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

**However, we encourage you to tell us before you start participating in a clinical research study.** If you plan to be in a clinical research study, you or your [care coordinator/care manager (plan’s preference)] should contact Member Services to let us know you will be in a clinical trial.

## K2. Payment for services when you are in a clinical research study

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

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

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

## K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

## L1. Definition of a religious non-medical health care institution

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

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

## L2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is “non-excepted.”

* “Non-excepted” medical treatment is any care that is voluntary and not required by any federal, state, or local law.
* “Excepted” medical treatment is any care that is not voluntary and is required under federal, state, or local law.

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

* The facility providing the care must be certified by Medicare.
* Our plan’s coverage of services is limited to non-religious aspects of care.
* If you get services from this institution that are provided to you in a facility, the following applies:
* You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
* [Omit this bullet if not applicable.] You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

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

# Durable medical equipment (DME)

## M1. DME as a member of our plan

DMEincludes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of <plan name>, our plan will rent most DME items for you for a maximum of 10 months. [*Insert as applicable:* In some cases, it may be 13 months.] At the end of the rental period, our plan will transfer ownership of the DME item to you, and it is considered purchased. [*Insert as applicable:* Our plan may ***or***does ***or*** does not pay for maintenance fees.] Call Member Services to find out more.

## M2. DME ownership when you switch to Original Medicare or Medicare Advantage

If you are renting DME, there are extra things for you to consider if you decide to switch to Original Medicare or a Medicare Advantage plan.

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

**Note:** You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don’t have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or by calling 1‑800‑MEDICARE (1‑800‑633‑4227), 24 hours a day, 7 days a week. TTY users should call 1‑877‑486‑2048.

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

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

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

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

## M3. Oxygen equipment benefits as a member of our plan

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

* rental of oxygen equipment
* delivery of oxygen and oxygen contents
* tubing and related accessories for the delivery of oxygen and oxygen contents
* maintenance and repairs of oxygen equipment

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

## M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

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

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

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

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

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

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