Chapter 4: Benefits Chart

**Introduction**

This chapter tells you about the services <plan name> covers and any restrictions or limits on those services [Insert if the plan has cost sharing: and how much you pay for each service]. It also tells you about benefits not covered under our plan. Key termsand theirdefinitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

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

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# Your covered services [*insert if the plan has cost sharing:* and your out-of-pocket costs]

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

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

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

[Plans with **no** cost sharing for any services described in this chapter, insert: Because you get assistance from Healthy Connections Medicaid, you pay nothing for your covered services as long as you follow the plan’s rules. See Chapter 3 [plans may insert reference, as applicable] for details about the plan’s rules.]

If you need help understanding what services are covered, call your [care coordinator/care manager (plan’s preference)] and/or Member Services at the number at the bottom of the page.

# Rules against providers charging you for services

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

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

# Our plan’s Benefits Chart

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

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. [Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]

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

* Your Medicare and Healthy Connections Medicaid covered services must be provided according to the rules set by Medicare and Healthy Connections Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means services that are reasonable and necessary for the diagnosis or treatment of your illness or injury, 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 to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. The services must also be provided in an appropriate facility for your medical condition and follow generally accepted standards of medical care.
* You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.
* You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can see someone that is not your PCP or use other providers in the plan’s network. This is called a referral. Chapter 3 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.
* When you first join the plan, you can continue seeing the providers you see 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 seeing 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. A single case agreement is an exception to treat the provider as an in-network provider. 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>.
* Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization are marked in the Benefits Chart [insert as appropriate: by an asterisk (\*) **or** by a footnote **or** in bold type **or** in italic type]. [Insert if applicable: In addition, you must get prior authorization for the following services that are not listed in the Benefits Chart: [insert list].]
* [Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Enrollees with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:
* [*List all applicable chronic conditions here*.]

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

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

[Instructions on completing the Benefits Chart:

* For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.
* Include the following where appropriate: You should talk to your provider and get a referral.
* Plans must include any services provided in excess of the Medicare and Healthy Connections Medicaid requirements. Preventive services must be identified with the apple icon.
* Plans should clearly indicate which benefits are subject to prior authorization. (This can be done with asterisks, footnotes, bold type, or italic type. Plans should select one method of indication throughout the document; do not use multiple methods.)
* Plans may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Benefits Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* Plans must describe any restrictive policies, limitations, or monetary limits that might affect a beneficiary’s access to services within the chart.
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans should include all non-waiver LTSS in the chart in alphabetical order.
* All HCBS waiver services should be appended to the end of the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed.
* Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
* *Deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the “Uniformity Flexibility” benefits for which they are eligible.*
* *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.*]

# The Benefits Chart

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

| General services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Apple icon represents preventive services | Abdominal aortic aneurysm screening  A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.  [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Alcohol misuse screening and counseling  The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.  You can also get rehabilitative and recovery services focused on coping skills which will help you manage your symptoms and behaviors. These services may be in an individual or group setting.  [List any additional benefits offered.] | $0 |
|  | Ambulance services  Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.  Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan.  In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | $0 |
| Apple icon represents preventive services | Annual wellness visit  If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months.  **Note:** You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. | $0 |
| Apple icon represents preventive services | Bone mass measurement  The plan will 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.  The plan will pay for the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.  [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Breast cancer screening (mammograms)  The plan will pay for the following services:   * One screening mammogram every 12 months for women age 40 and older * Clinical breast exams once every 24 months   [List any additional benefits offered.] | $0 |
|  | Cardiac (heart) rehabilitation services  The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s [insert as appropriate: referral **or** order].  The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
| Apple icon represents preventive services | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:   * discuss aspirin use, * check your blood pressure, or * give you tips to make sure you are eating well.   [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Cardiovascular (heart) disease testing  The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Cervical and vaginal cancer screening  The plan will pay for the following services:   * For all women: Pap tests and pelvic exams once every 24 months * For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months   [List any additional benefits offered.] | $0 |
|  | Chiropractic services  The plan will pay for the following services:   * Adjustments of the spine to correct alignment * The plan will only pay for other chiropractic services that are medically necessary. * For other chiropractic services to be covered, you must have a significant health problem in the form of a neuromuscular condition. * Chiropractic services for diseases not directly related to your spine, such as rheumatoid arthritis, muscular dystrophy, multiple sclerosis (MS), pneumonia, and emphysema, are **not** covered. * [List any plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | $0 |
| Apple icon represents preventive services | Colorectal cancer screening  The plan will pay for the following services:   * Flexible sigmoidoscopy (or screening barium enema) every 48 months * Fecal occult blood test, every 12 months * Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months * DNA based colorectal screening, every 3 years   For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months  For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).  [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Counseling to stop smoking or tobacco use  If you use tobacco but do not have signs or symptoms of tobacco-related disease:   * The plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * The plan will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits.   [List any additional benefits offered.] | $0 |
|  | Dental services  <Plan name> will pay for the following services:  [List any plan-covered supplemental benefits offered, such as routine dental care, dental X-rays, and cleanings.]   * Emergency medical procedures performed by oral surgeons. * Dental procedures related to the following: * Organ transplants * Oncology * Radiation of the head and/or neck for cancer treatment * Chemotherapy for cancer treatment * Total joint replacement * Heart valve replacement * Trauma treatment performed in a hospital or ambulatory surgical center | $0 |
| Apple icon represents preventive services | Depression screening  The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Diabetes screening  The plan will 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 are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months  [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Diabetic self-management training, services, and supplies  The plan will 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, the plan will pay for the following: * One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** * One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)   The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.   * The plan will pay for training to help you manage your diabetes, in some cases. * You are eligible for Diabetes Management Services if your provider determines this will help you. * You are limited to 10 hours of diabetes education in your lifetime.   [List any additional benefits offered.] | $0 |
|  | Durable medical equipment (DME) and related supplies  (For a definition of “Durable medical equipment (DME),” see Chapter 12 [plans may insert reference, as applicable] of this handbook.)  The following items are covered:   * Wheelchairs * Crutches * Powered mattress systems * Diabetic supplies * Hospital beds ordered by a provider for use in the home * Intravenous (IV) infusion pumps * Speech generating devices * Oxygen equipment and supplies * Nebulizers * Walkers   Other items may be covered.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Healthy Connections Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  [Plans that limit the DME brands and manufacturers that you will cover, insert the following (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.): With this Member Handbook, we sent you <plan name>’s list of DME. The list tells you the brands and makers of DME that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  *Additionally, if applicable, plans can add:* White canes for the blind are not covered*.*  This benefit is continued on the next page | [If copay amounts are different for Medicare and Medicaid-covered items, explain to which services any different copay amounts in this category would apply. For example, “The copay is $0 for durable medical equipment covered by Medicare. The copay is <amount, not to exceed $3.40> for durable medical equipment covered only by Healthy Connections Medicaid.” If copay amounts are different for Medicare and Medicaid-covered items, say “The copay is either $0 or <amount, not to exceed $3.40>, depending on the type of durable medical equipment.”] |
|  | **Durable medical equipment (DME) and related supplies**  **(continued)**  Generally, <plan name> covers any durable medical equipment covered by Medicare and Healthy Connections Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to <plan name> and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)  If you (or your doctor) do not agree with the plan’s coverage decision, you or your doctor may file an appeal. You can also file an appeal if you do not agree with your doctor’s decision about what product or brand is right for your medical condition. (For more information about appeals, see Chapter 9 [*plans may insert reference, as applicable*]*.*)]  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. However, <plan name> does not pay for maintenance fees. |  |
|  | Emergency care  Emergency care means services that are:   * given by a provider trained to give emergency services, **and** * needed to treat a medical emergency.   A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:   * serious risk to your health; **or** * serious harm to bodily functions; **or** * serious dysfunction of any bodily organ or part.   Emergency services are only covered when you get them within the U.S. | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plans should insert information as needed to accurately describe emergency care benefits:(e.g. you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.)] |
|  | [Plans should modify this as necessary.]  Family planning services  The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy, or family planning office.  The plan will pay for the following services:   * Family planning exam and medical treatment * Family planning lab and diagnostic tests * Family planning methods * Family planning supplies with prescription (condoms) * Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions * Treatment for sexually transmitted infections (STIs) * Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)   The plan will also pay for some other family planning services. However, you must see a provider in the plan’s network for the following services:   * Treatment for medical conditions of infertility * Treatment for AIDS and other HIV-related conditions * Genetic testing | $0 |
| Apple icon represents 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.]  The plan has a range of health and wellness education programs activities for members, their family members, and other informal caregivers. Some examples of topics that may be covered are:   * Self-management for chronic conditions * Quitting smoking * Preventing falls * Caregiver support * Nutrition * Alcohol and drug abuse * Managing your medications * Fitness * Disease planning * Preparing for emergencies | $0 |
|  | [Plans that cover hearing services should modify the following description if necessary. Add the apple icon if listing only preventive services.]  Hearing services  The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  [List any additional benefits offered, such as routine hearing exams, hearing aids, and evaluations for fitting hearing aids.]  If you have a cochlear implant or a surgically implanted hearing device, the plan pays for replacement parts. | $0 |
|  | [If this benefit is not applicable, plans should delete this row.]  **Help with certain chronic conditions**  [Plans that offer targeted “Uniformity Flexibility” supplemental benefits, which enrollees 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. The benefits listed here must be approved in the Plan Benefit Package submission.] | [List copays.] |
| Apple icon represents preventive services | HIV screening  The plan pays for one HIV screening exam every 12 months for people who:   * ask for an HIV screening test, **or** * are at increased risk for HIV infection.   Members who have HIV or AIDS can get extra services by joining a Community Long Term Care (CLTC) waiver program. See [insert reference] for more information about services for members who qualify.  [List any additional benefits offered.] | $0 |
|  | Home health agency care  [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.  The plan will pay for the following services, and maybe other services not listed here:   * Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies (including, but not limited to, incontinence supplies) | [Explain to which services any different copay amounts in this category would apply. For example, “*Home health care services covered by Medicare have a $0 copay. Personal care services covered by Healthy Connections Medicaid have a $3.30 copay.”*] |
|  | **Hospice care**  You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will pay for the following while you are getting hospice services:   * Drugs to treat symptoms and pain * Short-term respite care * Home care   **Hospice services and services covered by Medicare Part A or B are billed to Medicare:**   * See Section G of this chapter for more information.   **For services covered by <plan name> but not covered by Medicare Part A or B:**   * <Plan name> will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay [insert as appropriate: the plan’s cost sharing amount ***or*** nothing] for these services.   **For drugs that may be covered by <plan name>’s Medicare Part D benefit:**   * Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5 [*plans may insert reference, as applicable*].   This benefit is continued on the next page | [*Plan to fill in payment information, including any copays for home health*] |
|  | **Hospice care (continued)**  **Note**: If you need non-hospice care, you should call your [care coordinator/care manager *(plan’s preference)*] to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [*Plans should include a phone number or other contact information for the* care [coordinator*/*care manager(plan’s preference)]*.*]  [*Insert if applicable, edit as appropriate:* Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospicebenefit.] |  |
| Apple icon represents preventive services | Immunizations  The plan will pay for the following services:   * Pneumonia vaccine * Flu shots, once a year, in the fall or winter * Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B * Other vaccines if you are at risk and they meet Medicare Part B coverage rules   The plan will pay for other vaccines that meet the Healthy Connections Medicaid or Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more.  [List any additional benefits offered.] | $0 |
|  | Incontinence supplies  The plan will pay for incontinence supplies if your doctor believes you need them. The quantities and frequencies of supplies are determined by your level of incontinence. | $0 |
|  | Infusion therapy  The plan covers infusion pumps (and some medicines used in infusion pumps) that a doctor prescribes for use in your home.  If you don’t want to get infusion therapy in a doctor’s office or hospital, you can use an infusion center. See [insert reference to provider directory] for a list of infusion centers. You can get the following services at an infusion center:   * Chemotherapy * Hydration * Intravenous immunoglobulin (IVIG) * Blood and blood products * Antibiotics * Intrathecal/lumbar puncture * Inhalation * Therapeutic phlebotomy   A doctor will be on-site at the infusion center in case there are medical emergencies. | $0 |
|  | Inpatient hospital care  [List any restrictions that apply.]  The plan will pay for the following services, and maybe other services not listed here:   * Semi-private room (or a private room if it is medically necessary) * Meals, including special diets * Regular nursing services * Costs of special care units, such as intensive care or coronary care units * Drugs and medications * Lab tests * X-rays and other radiology services * Needed surgical and medical supplies * Appliances, such as wheelchairs * Operating and recovery room services * Physical, occupational, and speech therapy * Inpatient substance abuse services * Blood, including storage and administration * Physician services * In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.   If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [*Plans should include the following, modified as appropriate:* Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community.  This benefit is continued on the next page | $0  You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. |
|  | Inpatient hospital care (continued)  If <plan name> provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.][*Plans may further define the specifics of transplant travel coverage.*] |  |
|  | Inpatient mental health care   * The plan will pay for mental health care services that require a hospital stay. * There is a 190-day lifetime limit for inpatient mental health care in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. * After you use your 190 days, these services are available at an Institution for Mental Diseases (IMD). * An IMD is defined as an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. * Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. | $0 |
|  | [Plans with no day limitations on a plan’s hospital or nursing home coverage may modify or delete this row as appropriate.]  Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay  If your inpatient stay is not reasonable and necessary, the plan will not pay for it.  However, in some cases the plan will pay for services you get while you are in the hospital or a nursing home. The plan will pay for the following services, and maybe other services not listed here:   * Doctor services * Diagnostic tests, like lab tests * X-ray, radium, and isotope therapy, including technician materials and services * Surgical dressings * Splints, casts, and other devices used for fractures and dislocations * Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: * replace all or part of an internal body organ (including contiguous tissue), or * replace all or part of the function of an inoperative or malfunctioning internal body organ. * Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition * Physical therapy, speech therapy, and occupational therapy | $0 for most items  <amount not to exceed $3.40> for prosthetics, orthotic devices, and medical supplies covered only by Healthy Connections Medicaid |
|  | Kidney disease services and supplies  The plan will pay for the following services:   * Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. * Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable] * Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care * Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments * Home dialysis equipment and supplies * Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply   Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart. | $0 |
| Apple icon indicates preventive services. | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:   * Are aged 55-77, **and** * Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** * Have smoked at least one pack a day for 30 years with no signs or symptoms of lung cancer *or* smoke now or have quit within the last 15 years.   After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [insert as appropriate: referred **or** ordered] by your doctor.  The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We 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 your treatment is needed in the next calendar year.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | Medicare Diabetes Prevention Program (MDPP)  The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:   * long-term dietary change, **and** * increased physical activity, **and** * ways to maintain weight loss and a healthy lifestyle. | $0 |
|  | Medicare Part B prescription drugs  These drugs are covered under Part B of Medicare. <Plan name> will pay for the following drugs:   * Drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services * Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan * Clotting factors you give yourself by injection if you have hemophilia * Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant * Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself * Antigens * Certain oral anti-cancer drugs and anti-nausea drugs * Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) * IV immune globulin for the home treatment of primary immune deficiency diseases   Chapter 5 [plans may insert reference, as applicable] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [plans may insert reference, as applicable] explains what you pay for your outpatient prescription drugs through our plan. | $0 |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Nursing home care  Your plan will cover the following services:   * Nursing services: all nursing services to meet the total needs of the resident. * Special services: assistance from social workers, planned activities, and various therapies * Personal services: assistance with eating, dressing, toilet functions, baths, etc. * Room and board: semi-private or ward accommodations * Safety and treatment equipment: wheelchairs, infusion equipment, bedside commode, etc. * Medications: over-the counter medications (except for insulin) * Medical supplies and oxygen: oxygen, equipment for inhalation therapy, catheters, dressings, etc.   Services that are not covered include physician services, lab/x-ray, inpatient and outpatient hospital services, prescription drugs, etc.  Please note that skilled nursing facility (SNF) care is covered under its own category in this chart. | Please contact your care manager to learn if you will need to contribute toward your nursing home care. |
|  | **Nursing home transition services**  Nursing home transition services are available if you are in a nursing home and want to move back into your community. The services help if you have a disability or mental health condition. The following services are available if you go from a nursing home to a community waiver program:   * Appliance services which provide necessary appliances * Furniture to establish a home in the community * One-time assistance with rent or utilities   The Home Again program is designed to help people who have lived in a nursing home and wish to return to the community through participating in one of the three Community Long Term Care (CLTC) waiver programs. If you lived in a nursing facility for at least 90 days, you may qualify for the program and get the following services:   * Transition coordination * Crisis intervention * Expanded employment services * Expanded assistive devices * Expanded goods and services * Wireless sensors * Community living services * Guided care nurse * Service animals   If you think you qualify for the program, talk to your [care coordinator/care manager (plan’s preference)]. | $0 |
| Apple icon represents preventive services | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, the plan will 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 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  The plan will pay for the following services, and maybe other 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 * Other outpatient diagnostic tests   [Plans can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will pay for the following services, and maybe other services not listed here:   * Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery * 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 plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will 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 nurse practitioner, * a physician assistant, * a licensed marriage and family therapist, * a licensed professional counselor, **or** * any other Medicare-qualified mental health care professional as allowed under applicable state laws.   The plan will pay for the following services, and maybe other services not listed here:   * Clinic services * Day treatment * Psychosocial rehab services   [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan will pay for physical therapy, occupational therapy, and speech therapy. Physical therapy services must improve or restore your physical function and prevent injury, impairments, and disabilities after a disease, injury, or loss of a body part.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | Outpatient substance abuse services  [Describe the plan’s benefits for outpatient substance abuse services.]  Medicare Part B helps pay for outpatient substance abuse treatment services from a clinic or hospital outpatient department.  Covered services include, but are not limited to:   * Psychotherapy * Patient education * Follow-up care after you leave the hospital * Prescription drugs during a hospital stay or injected at a doctor’s office. * Preventive screening and counseling | $0 |
|  | Outpatient surgery  The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | Palliative care  Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.  Palliative care is provided by a team that may include doctors, nurses, social workers, chaplains, and others who work with a patient's other doctors to provide an extra layer of support. The team will:   * Talk to members about what matters most to them * Assess and manage pain and other symptoms * Address psychological and spiritual needs of members and their family * Offer support to help members live as fully as possible * Offer a support system to help the family cope during the member’s illness   Palliative care is appropriate at any age and at any stage in a serious illness, and it can be provided together with curative treatment. | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Partial hospitalization services  Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor’s or therapist’s office. It can help keep you from having to stay in the hospital.  [Network plans that do not have an in-network community mental health center may add: **Note**: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | Physician/provider services, including doctor’s office visits  The plan will 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 it to see whether you need treatment * [Insert if the plan has a service area and providers/locations that qualify for telehealth services under the Medicare requirements: Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare] * Second opinion [insert if appropriate: by another network provider] before a medical procedure * Non-routine dental care. Covered services are limited to: * surgery of the jaw or related structures, * setting fractures of the jaw or facial bones, * pulling teeth before radiation treatments of neoplastic cancer, **or** * services that would be covered when provided by a physician.   [List any additional benefits offered.] | $0 |
|  | Podiatry services  The plan will 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   [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Prostate cancer screening exams  For men, the plan will 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 plan-covered supplemental benefits as appropriate.]  Prosthetic devices and related supplies  Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here if your provider gets prior approval:   * Colostomy bags and supplies related to colostomy care * Pacemakers * Braces * Prosthetic shoes * Artificial arms and legs * Breast prostheses (including a surgical brassiere after a mastectomy)   The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.  The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section [plans may insert reference, as applicable] for details.  [Plans that pay for prosthetic dental devices, delete the following sentence:] The plan will not pay for prosthetic dental devices. | [If copay amounts are different for Medicare and Medicaid-covered items, explain for what any different copay amounts in this category would apply. For example, “The copay is $0 for prosthetic devices covered by Medicare. The copay is <amount, not to exceed $3.40> for prosthetic devices covered only by Healthy Connections Medicaid.”] |
|  | Pulmonary rehabilitation services  The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have [insert as appropriate: a referral **or** an order] for pulmonary rehabilitation from the doctor or provider treating the COPD.  [List any additional benefits offered.] | $0 |
| Apple icon represents preventive services | Sexually transmitted infections (STIs) screening and counseling  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered 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.  The plan will 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. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office.  [Also list any additional benefits offered.] | $0 |
|  | Skilled nursing facility (SNF) care  [List days covered and any restrictions that apply, including whether any prior authorization, referral, or prior hospital stay is required.]  The plan will pay for the following services, and maybe other services not listed here:   * A semi-private room, or a private room if it is medically necessary * Meals, including special diets * Nursing services * Physical therapy, occupational therapy, and speech therapy * Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors * Blood, including storage and administration * Medical and surgical supplies given by nursing facilities * Lab tests given by nursing facilities * X-rays and other radiology services given by nursing facilities * Appliances, such as wheelchairs, usually given by nursing facilities * Physician/provider services   This benefit is continued on the next page | $0 |
|  | Skilled nursing facility (SNF) care (continued)  You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:   * A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) * A nursing facility where your spouse lives at the time you leave the hospital * Please note that nursing home care is covered under its own category in this chart. |  |
|  | Targeted Case Management (TCM)  TCM activities make sure that your medical, social, educational and other service needs are addressed on an ongoing basis to help you become more self-sufficient.  To get TCM, you have to be in one of the following groups:   * Individuals with Intellectual and Related Disabilities * Adults with Serious and Persistent Mental Illness * Individuals with Psychoactive Substance Disorder * Adults with Functional Impairments * Individuals with Sensory Impairments * Individuals with Head and Spinal Cord Injuries and Related Disabilities   TCM is only available for the last 180 days that you are in an institution and are moving to a community setting. Individuals who are moving into a waiver are not eligible for TCM.  Talk to your [care coordinator/care manager (plan’s preference)] or PCP about getting TCM services. | $0 |
|  | Telemedicine  The plan covers some medical or health services using real-time audio or video with a provider who isn’t at your location.  These services are available in some rural areas, under certain conditions, and only if you’re located at one of the following places: a doctor’s office, hospital, rural health clinic, federally-qualified health center, hospital-based dialysis facility, skilled nursing facility (SNF), or community mental health center.  The following services are covered using a telecommunication system:   * Consultation * Office visits * Individual psychotherapy * Prescription management * Psychiatric diagnostic interview exams and testing   Services such as telephone conversations, e-mail messages and video cell phone calls are not covered.  Tele-psychiatry is only provided on a limited basis through the Department of Mental Health in partnership with over 20 hospital emergency rooms in the state. | $0 |
|  | Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency, **or** * a sudden medical illness, **or** * an injury, **or** * a condition that needs care right away.   If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.  Urgent care is only covered when you get the services in the U.S. | $0 |
| Apple icon indicates preventive services. | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Medicare does not cover regular eye exams for glasses or contacts.  Healthy Connections Medicaid covers the following services:   * Treatment for an illness or injury to the eye * Initial replacement of the lens due to cataract surgery   For people at high risk of glaucoma, the plan will 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 age 50 and older, and * Hispanic Americans who are 65 or older.   [Plans should modify this description if the plan offers more than is covered by Medicare.] The plan will 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 cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)  [Also list any additional benefits offered, such as supplemental vision exams or glasses.] | $0 |
| Apple icon represents preventive services | “Welcome to Medicare” Preventive Visit  The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:   * a review of your health, * education and counseling about the preventive services you need (including screenings and shots), and * referrals for other care if you need it.   **Note**:We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

# Waiver Services Operated by Community Long Term Care (CLTC) that Our Plan Pays For

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. The type and amounts of LTSS depend on the waiver you are on. 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.

| Waiver services operated by Community and Long Term Care (CLTC) that our plan pays for | | What you must pay |
| --- | --- | --- |
|  | Community Choices Waiver services  The plan provides extra services for members on the Community Choices Waiver. These services include:   * Adult day health care and nursing * Transportation to adult day health care * Case management and coordination of these waiver services * Companion services * Home delivered meals * Minor home adaptations (for example, ramp, pest control, bath safety equipment) * Personal and attendant care * Personal emergency response system * Some nutritional supplements * Specialized medical equipment and supplies * Temporary relief for your caregiver in a Community Residential Care Facility (CRCF) or an in-patient facility (nursing facility or hospital) | $0 |
|  | HIV/AIDS Waiver services  The plan provides extra services for members on the HIV/AIDS Waiver. These services include:   * Additional prescription drugs * Case management and coordination of these waiver services * Companion services * Home delivered meals * Minor home adaptations (for example, ramp, pest control, bath safety equipment) * Personal and attendant care * Private duty nursing * Some nutritional supplements | $0 |
|  | Mechanical Ventilator Dependent Waiver services  The plan provides extra services for members on the Mechanical Ventilator Dependent Waiver. These services include:   * Case management and coordination of these waiver services * Home delivered meals * Minor home adaptations (for example, ramp, pest control, bath safety equipment) * Personal and attendant care * Personal emergency response system * Prescription drugs * Private duty nursing * Some nutritional supplements * Specialized medical equipment and supplies * Temporary relief for your caregiver (in a nursing facility or at your home) | $0 |

# Our plan’s visitor or traveler benefits

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

Typically, if you are out of the plan’s service area for more than 6 months at a time, we must drop you from our plan. However, we offer a visitor/traveler program [specify areas where the visitor/traveler program is being offered] that will allow you to remain enrolled in our plan when you are outside of our service area for up to 12 months. This program is available to all <plan name> members who are in a visitor/traveler area. Under our visitor/traveler program, you can get all plan-covered services at in-network cost sharing prices. You can contact the plan for help in finding a provider when you use the visitor/traveler benefit.

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

# Benefits covered outside of <plan name>

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

The following services are not covered by <plan name> but are available through Medicare. You can get these services in the same way that you do today.

## G1. Hospice Care

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

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

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

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

### For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

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

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

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

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

The following services are not covered by <plan name> but are available through Healthy Connections Medicaid. You can get these services in the same way that you do today.

## G2. Dental services

Diagnostics (oral evaluation and x-rays), preventive care (annual cleaning), restorative care (fillings), and surgical care (extractions/removals) are covered on a fee-for-service basis with a $3.40 copay. Please contact your [care coordinator/care manager (plan’s preference)] for more information.

## G3. Non-emergency medical transportation

Transportation assistance is available to and from any medical appointment with a $0 copay. The type of assistance will depend of the member’s medical situation. Requests for urgent or same day requests (such as transportation assistance for routine hospital discharges) will be verified with health care providers to confirm that the short timing is medically necessary. **Any member needing emergency transportation should call 911.**

For more information, please contact your [care coordinator/care manager (plan’s preference)] or see the member brochure located at the website of LogistiCare, who is the transportation broker: <https://memberinfo.logisticare.com/scmember/Downloads.aspx>. If you have additional questions, please contact LogistiCare using the contact information for your region in the member brochure.

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

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

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

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

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

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

* Acupuncture.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* Dentures. However, dental care required to treat illness or injury may be covered as inpatient or outpatient care
* 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.
* Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3 [plans may insert reference, as applicable] for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
* [Plans should delete this if supplemental:] Eyeglasses, regular eye exams, radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids. However, the plan will pay for glasses after cataract surgery.
* Full-time nursing care in your home.
* Hearing exams, hearing aids, or exams to fit hearing aids.
* Naturopath services (the use of natural or alternative treatments).
* Non-prescription contraceptive supplies.
* 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.
* Personal items in your room at a hospital or a nursing home, such as a telephone or a television.
* Private room in a hospital, except when it is medically necessary.
* Routine foot care, except for the limited coverage provided according to Medicare guidelines.
* Services considered not “reasonable and necessary,” according to the standards of Medicare and Healthy Connections Medicaid, unless these services are listed by our plan as covered services.
* Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.
* Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.