[Plan should utilize the below table to auto-populate key terms throughout the document, using the following steps:

1. Update the values for each of the data fields in the table below by highlighting the text (including the angle brackets (< >)) and typing in the appropriate value.
2. Press Ctrl+A to select all text in the main document sections.
3. Press F9 to update the field references. If a box appears asking to update the Table of Contents, select “Update entire table” and press OK.
4. Double click on the header. Press Ctrl+A to select all header text.
5. Press F9 to update the field references in the header.
6. If the header does not populate throughout the document, steps 5 and 6 should be repeated for each header section in the document.
7. Double click on the footer, and press Ctrl+A to select all footer text.
8. Press F9 to update the field references in the footer.
9. If the footer does not populate throughout the document, steps 8 and 9 should be repeated for each footer section in the document.

|  |  |
| --- | --- |
| **Data Field (bookmarkName)** | **Value** |
| Plan Name (planName) | <plan name> |
| Toll-free Number (tollfreeNumber) | <toll-free number> |
| Days and Hours of Operation (daysAndHoursOfOperation) | <days and hours of operation> |
| Web Address (webAddress) | <web address> |
| TTY/TDD Number (ttytddnumber) | <tty number> |
| Name of Care Coordinator (nameOfCareCoordinator) | <name of care coordinator> |
| Member Services Name (memberServicesName) | <member services name> |
| Name of plan members (memberName) | Member |

*Note: Plan should be cognizant of grammar and capitalization and review the document to ensure the populated bookmarks appear appropriately throughout.*

*If an error message appears in the document indicating that the source could not be found (shown below), a bookmark may have been deleted.*

C:\Users\570630\AppData\Local\Temp\msohtmlclip1\02\clip_image001.jpg

*To recreate a bookmark, plan should use the following steps:*

1. *Highlight the value that is not updating.*
2. *On the Insert ribbon tab, in the Links group, select Bookmark.*
3. *Enter the bookmark name in parentheses after the data field name.*
4. *Follow the steps above to update the bookmarks.*]

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*.

[Plan 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 [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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

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# Your covered services

This chapter tells you what services <plan name> pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 [plan may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.] [Plan may insert reference, as applicable].

If you get or become eligible for long-term services and supports (LTSS), you may be required to pay part of the cost of these services. This amount is determined by Rhode Island Medicaid. If you are not getting or are not eligible to get LTSS, you pay nothing for your covered services as long as you follow the plan’s rules. See Chapter 3 [plan may insert reference, as applicable] for details about the plan’s rules.

If you need help understanding what services are covered, call your [plan may insert: <name of care coordinator> and/or <member services name>] at <member services number>. [Plan should include any other contact information.]

# 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[plan may insert reference, as applicable] or call <member services name>. The only exception to this is if you are getting LTSS and Rhode Island Medicaid says that you have to pay part of the cost of these services.

# Our plan’s Benefits Chart

[Plan 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. [If the plan includes an index at the end of the chapter, it 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.** Unless you are getting or are eligible for long-term services and supports (LTSS), you do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.If you get or become eligible for LTSS, you may be required to pay part of the cost of these services. This amount is determined by Rhode Island Medicaid.

* Your Medicare and Rhode Island Medicaid covered services must be provided according to the rules set by Medicare and Rhode Island Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need medical, surgical or other services to prevent, diagnose, or treat, a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary includes services to prevent a health-related condition from getting worse.
* 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 [plan 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. [If the plan does 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 [plan may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.
* 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 first 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.]

* 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, if the plan covers a richer benefit, there is no 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.
* The plan must include any services provided in excess of the Medicare and Rhode Island Medicaid requirements. Preventive services must be identified with the apple icon.
* The plan should clearly indicate which benefits are subject to prior authorization. (This can be done with asterisks, footnotes, bold type, or italic type. The plan should select only **one** method of indication throughout the document and must not use multiple methods.)
* The plan 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.
* The plan must describe any restrictive policies, limitations, or monetary limits that might affect a beneficiary’s access to services within the chart.
* The plan 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.
* Plan 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.
* Plan 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, plan enters 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, plan enters the benefit name again in bold followed by* **(continued).** *Plan may refer to* **Durable medical equipment (DME) and related supplies** *and other examples later in this chart as examples. Plan should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.*]

| **Services that our plan pays for** | | **What you must pay** |
| --- | --- | --- |
| Apple icon in the benfits chart showing preventive service | **Abdominal aortic aneurysm screening**  The plan will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this as necessary.]  **Abortion**  The plan will not pay for an abortion except in cases of rape or incest or if the pregnancy threatens the life of the mother. | $0 |
|  | Adult Day Services  The plan will pay for adult day services.  [List any additional benefits offered, including different levels of service available.] | $0 |
|  | **Alcohol misuse screening and counseling**  The plan will pay for alcohol-misuse screening.  If you screen positive for alcohol misuse, the plan covers counseling sessions with a qualified provider or practitioner.  [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 in the benfits chart showing preventive service | **Annual wellness visit**  The plan will pay for an annual checkup once every 12 months. This is to make or update a prevention plan based on your current risk factors. | $0 |
| Apple icon in the benfits chart showing preventive service | **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 also pay for a provider to look at and comment on the results.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | **Breast cancer screening (mammograms)**  The plan will pay for mammograms and clinical breast exams.  [*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 provider’s [insert as appropriate: referral **or** order].  The plan also covers intensive cardiac rehabilitation programs, which are more intense than standard cardiac rehabilitation programs. | $0 |
| Apple icon in the benfits chart showing preventive service | **Cardiovascular (heart) disease risk reduction visits (therapy for heart disease)**  The plan pays for visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may:  discuss aspirin use,  check your blood pressure, or  give you tips to make sure you are eating well.  [*List any additional benefits offered.*] | $0 |
| Apple icon in the benfits chart showing preventive service | **Cardiovascular (heart) disease testing**  The plan pays for blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | **Cervical and vaginal cancer screening**  The plan will pay for pap tests and pelvic exams.  [List any additional benefits offered.] | $0 |
|  | **Chiropractic services**  The plan will pay for the following services:  Adjustments of the spine to correct alignment  [List any Rhode Island Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | $0 |
| Apple icon in the benfits chart showing preventive service | **Colorectal cancer screening**  The plan will pay for:  Flexible sigmoidoscopy (or screening barium enema)  Fecal occult blood test  Screening colonoscopy (or screening barium enema)  Guaiac-based fecal occult blood test **or** fecal immunochemical test, every 12 months or as medically necessary  DNA based colorectal screening, every 3 years or as medically necessary  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | **Counseling to stop smoking or tobacco use**  If you use tobacco the plan will pay for face-to-face counseling to help you stop smoking or using tobacco   * The plan will also pay for telephone counseling and support.   [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | **Depression screening**  The plan will pay for depression screening. 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 in the benfits chart showing preventive service | **Diabetes screening**  The plan will pay for diabetes screening (includes fasting glucose tests).  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | **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.  [List any additional benefits offered.] | $0 |
|  | [If the plan covers durable medical equipment as a Rhode Island Medicaid benefit, modify the following description if necessary.]  Durable Medical Equipment (DME) and related supplies  (For a definition of “Durable Medical Equipment (DME),” see Chapter 12 [plan may insert reference, as applicable] of this handbook.)  The following are examples of DME items that 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.  [If the plan does not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Rhode Island 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.]  [If the plan limits 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 <web address>.  **This benefit is continued on the next page**  Durable Medical Equipment (DME) and related supplies (continued)  Generally, <plan name> covers any (DME) covered by Medicare and Rhode Island 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 provider to decide what brand is medically right for you after this 90-day period. (If you disagree with your provider, you can ask him or her to refer you for a second opinion.)  If you (or your provider) do not agree with the plan’s coverage decision, you or your provider may file an appeal. You can also file an appeal if you do not agree with your provider’s decision about what product or brand is right for your medical condition. (For more information about appeals, see Chapter 9 [*plan may insert reference, as applicable*]*.*)] | $0 |
|  | **Emergency care**  Emergency care means services that are:  given by a provider trained to give emergency services, **and**  needed to treat a medical emergency.  A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:  serious risk to your health or to that of your unborn child; **or**  serious harm to bodily functions; **or**  serious dysfunction of any bodily organ or part; **or**  in the case of a pregnant woman in active labor, when:   * + there is not enough time to safely transfer you to another hospital before delivery.   + a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.   The plan will pay for emergency care and emergency transportation services.  [Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.] | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plan 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.)]. |
|  | **Environmental or home modifications**  The plan will pay for changes to your home or vehicle to help you live safely at home. The following are examples of services that are covered:   * Grab bars * Shower chairs * Eating utensils * Raised toilet seats * Wheelchair ramps * Standing poles   Other services may also be covered. | $0 |
|  | [Plan should modify this as necessary.]  Family planning services  The law lets you choose any provider to get certain family planning services from. This means you can get family planning services from any network or out-of-network provider, 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 (birth control pills, patch, ring, IUD, injections, implants)  Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)  Counseling and diagnosis of infertility, and related services  Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions  Treatment for sexually transmitted infections (STIs)  Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)  Genetic counseling  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 AIDS and other HIV-related conditions, including medical case management for people living with HIV/AIDS and non-medical care management services for people living with HIV/AIDS or are at risk for HIV  Genetic testing | $0 |
| Apple icon in the benfits chart showing preventive service | [*If this benefit is not applicable, plan should delete this row.*]  **Health and wellness education programs**  [These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of *Member*s include weight management, fitness, and stress management. Describe the nature of the programs here.] | $0 |
|  | [If the plan covers hearing services as a Rhode Island Medicaid benefit, modify the following description if necessary. Add the apple icon if listing only preventive services.]  Hearing services  The plan pays for routine hearing exams and hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  The plan also covers hearing aids and evaluations for fitting hearing aids once every three years.  [List any additional benefits offered.] | $0 |
|  | [If this benefit is not applicable, plan should delete this row.]  **Help with certain chronic conditions**  [Plan that offers 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 in the benfits chart showing preventive service | **HIV screening**  The plan pays for HIV screening exams and HIV screening tests. The plan will also pay for medical case management for people living with HIV/AIDS and non-medical care management services for people living with HIV AIDS or are at risk for HIV.  [List any additional benefits offered.] | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  Home care services  The plan will pay for personal care services, such as help with dressing and eating, and homemaking services, such as laundry and shopping. Home care services do not include respite care or day care.  The plan may also pay for other services not listed here.  [List any additional benefits offered.] | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  Home health agency care  Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency.  The plan will pay for the following services:   * Full-time, part-time or intermittent skilled nursing, certified nursing assistant, and home health aide services * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies   The plan may also pay for other services not listed here. | $0 |
|  | **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 provider 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 F of this chapter for more information.  **For services covered by <plan name> but not covered by Medicare Part A or B:**  <plan name> will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay [insert as appropriate: the plan’s cost sharing amount ***or*** nothing] for these services.  This benefit is continued on the next page |  |
|  | **Hospice care (continued)**  **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 [plan may insert reference, as applicable].   **Note:** If you need non-hospice care, you should call your <name of care coordinator> to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plan should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
| Apple icon in the benfits chart showing preventive service | **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 or Rhode Island Medicaid coverage rules  The plan will pay for other vaccines that meet the Rhode Island Medicaid or Medicare Part D coverage rules. Read Chapter 6 [plan may insert reference, as applicable] to learn more.  [List any additional benefits offered.] | $0 |
|  | **Inpatient hospital care**  [List any restrictions that apply.]  The plan will pay for medically necessary inpatient hospital care. The plan covers the following services :  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 and other diagnostic tests  X-rays and other radiology services, including technician materials and services  Needed surgical and medical supplies  Appliances, such as wheelchairs  Operating and recovery room services  Physical, occupational, and speech therapy  Inpatient substance use treatment services  Blood, including storage and administration   * + The plan will pay for whole blood, packed red cells and all other parts of blood.   Physician services  Transplants, including corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. Other types of transplants may be covered.  **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 you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plan should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If <plan name> provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.]  [Plan may further define the specifics of transplant travel coverage.] |  |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  Inpatient mental health care   * The plan will pay for mental health care services that require a hospital stay. | $0 |
|  | 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 provider 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 [plan 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 in the benfits chart showing preventive service | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:  Are aged 55-77, **and**  Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and**  Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.  After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [*List any additional benefits offered.*] | $0 |
| 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 provider 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 [*plan 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 [*plan may insert reference, as applicable*] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [*plan may insert reference, as applicable*] explains what you pay for your outpatient prescription drugs through our plan. | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  **Nursing facility care** | [*List copays.*]  If you get nursing facility care, you may have to pay part of the cost of your services. The amount is determined by Rhode Island Medicaid. |
|  | Nutritional/dietary benefit  The plan will pay for medical nutrition therapy and counseling delivered by a licensed dietician to help you manage a chronic condition or medical problem such as diabetes, high blood pressure, obesity, or cancer. The plan will also pay for medical nutrition therapy and counseling if you are taking a medication that can affect your body’s ability to absorb nutrients or your metabolism.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | **Obesity screening and therapy to keep weight down**  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 providerto find out more.  [*List any additional benefits offered.*] | $0  [List copays for additional benefits.] |
|  | **Outpatient diagnostic tests and therapeutic services and supplies**  The plan will pay for the following services:   * 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 * Incontinence supplies, such diapers, underpads, and liners [*Plan may move incontinence supplies to a more appropriate category in the Benefits Chart if it would like to do so.*] * Lab tests * Blood and blood storage and administration * Other outpatient diagnostic tests   The plan may also pay for other services not listed here.  [*Plan 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:   * 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 provider 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   The plan may also pay for other services not listed here.  [*List any additional benefits offered.*] | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  **Outpatient mental health care**  The plan will pay for mental health services provided by:   * community mental health centers, * a state-licensed psychiatrist or doctor, * a clinical psychologist, * a clinical social worker, * a clinical nurse specialist, * a nurse practitioner, * a physician assistant, **or** * any other Medicare- or Rhode Island Medicaid-qualified mental health care professional as allowed under applicable state laws.   The plan will pay for the following:   * Clinic services * Individual, group, and family treatment * Crisis intervention and stabilization * Emergency services * Diagnostic evaluation * Psychological testing * Medication evaluation and management * Specialized services for people with serious mental illness, including Integrated Health Home and Assertive Community Treatment * Partial hospitalization * Day/evening treatment * Intensive outpatient treatment * Clubhouse * Integrated dual diagnosis treatment for people with mental illness and substance use disorders   **This benefit is continued on the next page**  **Outpatient mental health care (continued)**   * Court-ordered mental health treatment   The plan may also pay for other services not listed here.  [*List any additional benefits offered.*] | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  **Outpatient rehabilitation services**  The plan will pay for physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, and respiratory therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | **Outpatient substance use treatment services**  The plan will pay for:   * Substance use counseling * Medication-assisted opioid treatment programs, including methadone dosing and counseling and prescriptions for other medications such as suboxone * Opioid Treatment Program (OTP) Health Home services, which provide resources to opioid dependent Members who are currently receiving or who meet criteria for medication-assisted treatment * Medically managed detoxification in a hospital setting or a detoxification program * Integrated dual diagnosis treatment for people with mental illness and substance use disorders * Court-ordered substance use treatment   The plan may also pay for other services not listed here.  [*List any additional benefits offered.*] | $0 |
|  | **Outpatient surgery**  The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $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 careprovider***or***specialist], if your provider 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 and oral health care, including operating room charges and anesthesia services. 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 in the benfits chart showing preventive service | **Prostate cancer screening exams**  The plan will pay for the following services:   * A digital rectal exam * A prostate specific antigen (PSA) test   [*List any additional benefits offered.*] | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  **Prosthetic devices and related supplies**  Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices:   * Colostomy bags and supplies related to colostomy care * Pacemakers * Braces * Prosthetic shoes * Artificial arms and legs * Breast prostheses (including a surgical brassiere after a mastectomy)   The plan will 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 [*plan may insert reference, as applicable*] for details.  [*If the plan pays for prosthetic dental devices, delete the following sentence:*]The plan will not pay for prosthetic dental devices.  The plan may pay for other devices not listed here. | $0 |
|  | **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 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  **Residential mental health and substance use treatment services**  The plan will pay for:   * Short- and long-term mental health treatment residential services. * Acute substance use residential treatment   [*List any additional benefits offered.*] | $0 |
|  | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.*]  **Services to prevent a hospital or nursing facility admission**  The plan will pay for a limited set of services for people at high risk for a hospitalization or a nursing facility admission, including:   * Homemaker services, such as meal preparation or routine household care * Minor changes to your home, such as grab bars, shower chairs, and raised toilet seats * Physical therapy services prior to surgery if the therapy will enhance recovery or reduce rehabilitation time * Physical therapy evaluation for home accessibility appliances or devices * Respite or temporary caregiving services   [*List any additional benefits offered and additional information on how to qualify for the services.*] | $0 |
| Apple icon in the benfits chart showing preventive service | **Sexually transmitted infections (STIs) screening and counseling**  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care providermust order the tests.  The plan will also pay for face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs.  [*Also list any additional benefits offered.*] | $0 |
|  | **Skilled nursing facility (SNF) care**  [*List days covered and any restrictions that apply, including whether any prior hospital stay is required.*]  The plan will pay for the following services:   * 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   + The plan will pay for whole blood, packed red, and all other parts of blood, including storage and administration, beginning with the first pint.   + 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)**  The plan may also pay for other services not listed here.  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 |  |
|  | **Special medical equipment/minor assistive devices**  The plan will pay for special medical equipment and supplies to make it easier for you to do daily activities, such as eating and bathing. | $0 |
|  | **Urgently needed care**  Urgently needed care is non-emergency care given to treat:   * a sudden medical illness, **or** * an acute injury, **or** * a condition that needs care right away.   If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.  [*Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.*] | $0 |
| Apple icon in the benfits chart showing preventive service | [*Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.*]  **Vision care**  The plan will pay for a routine eye exam and eyeglasses once every two years. Eyeglass lenses are covered more than once every two years only if it is medically necessary. Contact lenses may be covered if you have a visual or ocular condition that is better treated with contact lenses than with eyeglasses.  The plan will pay for outpatient doctor and other provider 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.  For people at high risk of glaucoma, the plan will pay glaucoma screenings. 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.   [*Plan 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 in the benfits chart showing preventive service | **“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 provider’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

Our plan also covers long-term services and supports (LTSS) for Members who need them and qualify for LTSS through Rhode Island Medicaid. You may need to pay for part of the cost of the services. The amount you pay is determined by Rhode Island Medicaid. [*Plan to provide additional information, before the table or in each row of the table, on how to qualify for the services, additional benefits covered and any service exclusions.*]

| **LTSS Services** | **What you must pay** |
| --- | --- |
| **Assisted living**  The plan will pay for services and supports for you to live in an assisted living facility. | Determined by Rhode Island Medicaid |
| **Community transition services**  The plan will provide services to help you move from a nursing facility or institution to a private home. The plan will also pay for some one-time living expenses to help you set up a private home when you move from a nursing facility or institution. | Determined by Rhode Island Medicaid |
| **Day supports**  The plan will pay for services to help you with self-help and social skills. | Determined by Rhode Island Medicaid |
| **Employment supports**  The plan will pay for services, such as supervision, transportation, or training, to help you get or keep a paid job. | Determined by Rhode Island Medicaid |
| **Homemaker**  The plan will pay for homemaker services to help with general householder tasks, such as meal preparation or general household care. | Determined by Rhode Island Medicaid |
| **Meals on Wheels**  The plan will pay for up to one meal five days per week to be delivered to your home. | Determined by Rhode Island Medicaid |
| **Personal care assistance**  The plan will pay for assistance with daily activities in your home or the community if you have a disability and are unable to do the activities on your own. | Determined by Rhode Island Medicaid |
| **Personal emergency response system**  The plan will pay for electronic devices to help you get help in an emergency. | Determined by Rhode Island Medicaid |
| **Private duty nursing**  The plan will pay for individual and continuous care provided by licensed nurses in your home. | Determined by Rhode Island Medicaid |
| **Rehabilitation Services**  The plan will pay for specialized physical, occupational, and speech therapy services at outpatient rehabilitation centers. | Determined by Rhode Island Medicaid |
| **Residential supports**  The plan will pay for services to help you with daily activities to live in your own home, such as learning how to prepare meals and do household chores. | Determined by Rhode Island Medicaid |
| **Respite**  The plan will pay for short-term or temporary caregiving services when a person who usually cares for you is not available to provide care. | Determined by Rhode Island Medicaid |
| **RIte @ Home (Supported Living Arrangements – Shared Living)**  The plan will pay for personal care and other services provided by a caretaker who lives in the home. | Determined by Rhode Island Medicaid |
| **Self-directed services and supports**  If you are enrolled in the Personal Choice program, the plan will pay for:   * Services, equipment and supplies that help you live in the community * Services to help you direct and pay for your own services | Determined by Rhode Island Medicaid |
| **Senior/adult companion**  The plan will pay for non-medical help and social support with daily activities, such as meal preparation, laundry, and shopping. | Determined by Rhode Island Medicaid |
| **Skilled nursing services**  The plan will pay for skilled nursing services. | Determined by Rhode Island Medicaid |

# Our plan’s visitor or traveler benefits

[If the plan offers a visitor/traveler program to members who are out of its 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.]

# Benefits covered outside of <plan name>

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

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

## F1. Hospice Care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice provider 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 [plan may insert reference, as applicable].

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

## F2. Dental services

Regular dental care, such as cleanings, fillings or dentures, are covered by Rhode Island Medicaid. However, dental care required to treat illness or injury may be covered by the plan as inpatient or outpatient care. Call <plan name> at <toll-free number> [TTY/TDD: ] if you are not sure whether the plan or Rhode Island Medicaid covers the dental services you need or if you need help finding a dentist.

## F3. Non-emergency transportation

You may be eligible for a reduced-fare RIPTA bus pass. To get a reduced-fare RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903 or the RIPTA Customer Service Office at 705 Elmwood Avenue, Providence, RI 02907. Call RIPTA at 1-401-784-9500 ext. 604 for more information.

If you are unable to use a RIPTA bus pass, Rhode Island Medicaid covers non-emergency transportation. If you need non-emergency transportation, call 1-855-330-9131 (TTY 1-866-288- 3133) or <plan name> at <toll-free number> [TTY/TDD: ]. You may ask for urgent care transportation 24 hours a day, seven days a week. Transportation for non-urgent care must be scheduled at least two business days before your appointment. [*Plan should add additional information on accessing transportation services as needed.*]

## F4. Residential services for people with intellectual and developmental disabilities

Residential services for people with intellectual and developmental disabilities are covered by Rhode Island Medicaid. Call <plan name> at <toll-free number> [TTY/TDD: ] if you are unsure whether the services you need are covered by the plan or Rhode Island Medicaid.

## F5. Home stabilization services

If you are homeless, at risk for becoming homeless, or moving from a nursing facility to the community, you may able to get services from Rhode Island Medicaid to help you with housing-related problems. If you have questions about the services that Rhode Island Medicaid covers or if you would like a referral to this program, call <plan name> at <toll-free number>, [TTY/TDD: ].

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

Services considered not “reasonable and necessary,” according to the standards of Medicare and Rhode Island Medicaid, unless these services are listed by our plan as covered services.

Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3, pages <page numbers>, for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.

Surgical treatment for morbid obesity, except when it is medically necessary and Medicare or Rhode Island Medicaid pays for it.

A private room in a hospital, except when it is medically necessary.

Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.

[Plan should delete this if State allows for this:] Fees charged by your spouse, guardian, or legal representative.

Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.

Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.

* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.

Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.

[Plan should delete this if supplemental:] Radial keratotomy, LASIK surgery, and vision therapy, and other low-vision aids.

Reversal of sterilization procedures, and non-prescription contraceptive supplies.

Acupuncture.

* Naturopath services (the use of natural or alternative treatments).

Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and there is VA cost sharing, we will reimburse the veteran for the amount he or she paid.