Chapter 4: Benefits Chart

**Introduction**

This chapter tells you about the services <plan name> coversand any restrictions or limits on those services [*Insert if the plan has cost sharing:* andhow 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

This chapter tells you what services <plan name> covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, and information about what you pay for drugs is in Chapter 6 [plans may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.]

With <plan name>, you pay nothing for the covered services in this chapter 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. This Covered Services List is for your general information only. Please call <plan name> for the most up to date information. MassHealth regulations are one of the factors that control the services and benefits available to you. To access MassHealth regulations:

* Go to MassHealth’s Web site at <http://www.mass.gov/masshealth>; or
* Call MassHealth Customer Service at 1-800-841-2900, TTY: 1-800-497-4648 (for people who are deaf, hard of hearing or speech disabled), Monday through Friday from 8:00 AM – 5:00 PM.

If you need help understanding what services are covered, call your Care Coordinator. [Plans should replace the term “Care Coordinator” as needed throughout this chapter with the term they use and include a phone number or other contact information.]

# Rules against providers charging you for services

We do not allow <plan name> providers to bill you for covered services. You should never get a bill from a network provider for covered services. If you do, see Chapter 7 [plans may insert reference, as applicable] or call Member Services.

# Our plan’s Benefits Charts

The Benefits Charts tell you which services the plan covers. The charts list and explain 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 Charts only when the following rules are met.** 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 MassHealth covered services must be provided according to the rules set by Medicare and MassHealth.
* The services (including medical care, behavioral health care, long-term services and supports, other services, supplies, and equipment) must be medically necessary. Medically necessary means you reasonably need the 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 and that there is no other similar, less expensive service suitable for you.
* You get your care from a network provider. A network provider is a provider who works with <plan name>. In most cases, the plan will not cover 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.
* [Plans that do not require referrals, omit this paragraph:] In most cases, your [insert as appropriate: PCP **or** Care Coordinator **or** other individual] must give you approval before you can see someone that is not your PCP or use other providers. This is called a referral. Chapter 3 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.
* [Insert if applicable: Some of the services listed in the Benefits Charts are covered only if your Care Team, 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 Charts [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 Charts: [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.]

* Some of the services in the Benefits Charts are covered only if you and your Care Team decide that they are right for you and they are in your individualized Personal Care Plan.

[Instructions on completing the Benefits Charts:

* 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 <Care Coordinator, primary care provider, or other appropriate individual> and get a referral.
* Plans must include any services provided in excess of the Medicare and MassHealth requirements.
* 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 with no cost sharing for any type of service (i.e., no cost sharing at all) should delete the “what you must pay” column from every table. Plans with any type of cost sharing for services, including for pharmacy services, must leave the “what you must pay” column in all of the tables in this chapter.
* *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 Charts

[*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. Plans apply these formatting instructions in each table in section D.*]

| General services that our plan covers | **What you must pay** |
| --- | --- |
| Abdominal aortic aneurysm screening  The plan covers 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 |
| **Abortion services** | $0 |
| **Adult day health services**  The plan covers services from adult day health providers at an organized program. These services may include the following:   * nursing services and health oversight * therapy * assistance with activities of daily living * nutritional and dietary services * counseling services * activities * case management * transportation | $0 |
| **Adult foster care services**  The plan covers services from adult foster care providers in a residential setting. These services may include the following:   * assistance with activities of daily living, instrumental activities of daily living, and personal care * supervision * nursing oversight | $0 |
| Alcohol misuse screening and counseling  The plan covers alcohol-misuse screening.  If you screen positive for alcohol misuse, the plan covers counseling sessions with a qualified primary care [insert as appropriate: physician **or** provider] or practitioner in a primary care setting.  [List any additional benefits offered.] | $0 |
| Ambulance services  Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan.  In cases that are *not* emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | $0 |
| Audiologist services  The plan covers audiologist (hearing) exams and evaluations. | $0 |
| Bone-mass measurement  The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis).  These procedures identify bone mass, find bone loss, or find out bone quality. The plan will also cover a doctor looking at and commenting on the results.  [List any additional benefits offered.] | $0 |
| Breast cancer screening (mammograms)  The plan covers mammograms and clinical breast exams.  [List any additional benefits offered.] | $0 |
| Cardiac (heart) rehabilitation services  The plan covers cardiac-rehabilitation services, such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s [insert as appropriate: referral **or** order].  The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than standard cardiac rehabilitation programs. | $0 |
| Cardiovascular (heart) disease risk-reduction visit (therapy for heart disease)  The plan covers visits with your primary care [insert as appropriate: physician **or** provider] to help lower your risk for heart disease. During this visit, your doctor may:   * discuss aspirin use * check your blood pressure * give you tips to make sure you are eating well   [List any additional benefits offered.] | $0 |
| Cardiovascular (heart) disease testing  The plan covers blood tests to check for cardiovascular disease once. These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0 |
| Cervical and vaginal cancer screening  The plan covers pap tests and pelvic exams.  [List any additional benefits offered.] | $0 |
| Chiropractic services  The plan covers adjustments of the spine to correct alignment, office visits, and radiology services.  [List any restrictions, such as the maximum number of visits.] | $0 |
| Colorectal-cancer screening  The plan covers the following services:   * flexible sigmoidoscopy (or screening barium enema) * fecal occult blood test * guaiac-based fecal occult blood test *or* fecal immunochemical test * DNA based colorectal screening * screening colonoscopy (or screening barium enema)   [List any additional benefits offered.] | $0 |
| Community health center services  The plan covers services from a community health center. Examples include the following:   * office visits for primary care [insert as appropriate: physician **or** provider] and specialists * OB/GYN and prenatal care * pediatric services, including EPSDT * health education * medical social services * nutrition services, including diabetes self-management training and medical nutrition therapy * tobacco-cessation services * vaccines not covered by the Massachusetts Department of Public Health (MDPH) | $0 |
| Counseling to stop smoking or tobacco use  As a preventive service, the plan covers counseling on attempts to quit.  [List any additional benefits offered.] | $0 |
| **Day habilitation services**  The plan covers a program of services offered by day habilitation providers if you qualify because you have an intellectual or developmental disability. At this program, you develop a service plan that includes your goals and objectives and the activities to help you meet them. These services may include the following:   * nursing services and health care supervision * developmental-skills training * therapy services * life skills/adult daily living training | $0 |
| Dental services  The plan covers preventive, restorative and emergency oral health care. | $0 |
| Depression screening  The plan covers 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 |
| Diabetes screening  The plan covers diabetes screening (includes fasting glucose tests).  [List any additional benefits offered.] | $0 |
| Diabetic self-management training, services, and supplies  The plan covers the following services for all people who have diabetes or pre-diabetes (even if they don’t use insulin):   * 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 covers the following: * Therapeutic custom-molded shoes (including inserts), or * Depth shoes (including non-customized removable inserts)   The plan will also cover fitting the therapeutic custom-molded or depth shoes.   * In some cases, the plan covers training to help you manage your diabetes.   [List any additional benefits offered.] | $0 |
| Durable medical equipment (DME), including related supplies, replacement parts, training, modifications and repairs  (For a definition of “Durable medical equipment (DME),” see Chapter 12 [plans may insert reference, as applicable] of this handbook.)  The following items are examples of DME 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 DME items may be covered, including environmental aids or assistive/adaptive technology. The plan mayalso cover you learning how to use, modify, or repair your DME item. Your Care Team will work with you to decide if these other DME items and services are right for you and will be in your individualized Personal Care Plan.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We cover all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  **This benefit is continued on the next page** | $0 |
| Durable medical equipment (DME), including related supplies, replacement parts, training, modifications and repairs (continued)  [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>.  Generally, <plan name> covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to <plan name> and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask 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]*.*)] |  |
| Emergency medical 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 that anyone with an average knowledge of health and medicine could expect is so serious that if it doesn’t get immediate medical attention, it would 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; **or** * the transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.   [Also identify that the plan covers emergency care within the U.S. and its territories.]  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.] | $0 |
| [Plans should modify this as necessary.]  Family planning services  You may choose any provider in <plan’s name> network or a MassHealth provider to get certain family planning services. This means that you can pick any doctor, clinic, hospital, pharmacy, or family-planning office.  The plan covers 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, or implants) * Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, or cap) * Counseling and diagnosis of infertility * 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 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 medical conditions of infertility (this service does not include artificial ways to become pregnant) * Treatment for AIDS and other HIV-related conditions * Genetic testing | $0 |
| [Plans should modify this benefit as needed based on Medicare coverage guidelines.]  **Gender Reassignment**  The plan covers gender reassignment services. Services may include the following: mastectomy, breast augmentation, hysterectomy, salpingectomy, oophorectomy, or genital reconstructive surgery. | $0 |
| **Group adult foster care**  The plan covers services provided by group adult foster care providers for members who qualify. These services are offered in a group-supported housing environment and may include the following:   * assistance with activities of daily living, instrumental activities of daily living, and personal care * supervision * nursing oversight * care management | $0 |
| [If this benefit is not applicable, plans should delete this row.]  Health and wellness education programs  [These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. Describe the nature of the programs here.] | $0 |
| Hearing services, including hearing aids  The plan covers hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  The plan also covers the following:   * providing and dispensing hearing aids, batteries, and accessories * instruction in the use, care, and management of hearing aids * ear molds * ear impressions * loan of a hearing aid, when necessary   [List any additional benefits offered, such as routine hearing exams, hearing aids, and evaluations for fitting hearing aids.] | $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.*] | $0 |
| HIV screening  The plan covers HIV screening exams and HIV screening tests.  [List any additional benefits offered.] | $0 |
| Home health agency care  [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  The plan covers services provided by a home health agency including:   * 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, with certain exceptions) * physical therapy, occupational therapy, and speech therapy * medical and social services * transportation to your care or services * medical equipment and supplies | $0 |
| **Home health aide services**  The plan covers services from a home health aide, under the supervision of a licensed RN or other professional, for members who qualify. Services may include the following:   * simple dressing changes * assistance with medications * activities to support skilled therapies * routine care of prosthetic and orthotic devices | $0 |
| **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   If you choose to get your hospice care in a nursing facility, <plan name> will cover the cost of room and board.  **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.   **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** | $0 |
| **Hospice care (continued)**  Note: If you need hospice or non-hospice care, you should call your Care Coordinator to help arrange these services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should replace the term “Care Coordinator” with the term they use and include a phone number or other contact information.]  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
| Immunizations  The plan covers certain vaccines such as:   * Pneumonia * Flu shots * 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 * Other vaccines that meet the MassHealth or Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more.   [List any additional benefits offered.] | $0 |
| Independent nursing  The plan covers care from a nurse in your home. The nurse may either work for a home health agency or may be an independent nurse. | $0 |
| Inpatient behavioral health care  Inpatient services, such as:   * inpatient mental health services to evaluate and treat an acute psychiatric condition * inpatient substance use disorder services * observation/holding beds * administratively necessary day services   Under this plan, there is no lifetime limit on the number of days a member can have in an inpatient mental health care facility. | $0 |
| Inpatient hospital care  [List any restrictions that apply.]  The plan covers medically necessary inpatient stays. You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.  The plan covers services including:   * 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 * Surgical and medical supplies * Appliances, like wheelchairs * Operating and recovery room services * Physical, occupational, and speech therapy * Inpatient substance use disorder services * Blood, including storage and administration [modify as necessary if the plan begins coverage with an earlier pint:] * The plan covers whole blood, packed red cells, and all other parts of blood. * Physician services   **This benefit is continued on the next page** | $0 |
| Inpatient hospital care (continued)   * Transplants, including corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If <plan name> provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.] |  |
| [Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate.]  Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay  The plan covers services you get while you are in the hospital or a nursing facility. The plan covers services including:   * 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 |
| 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 orsmoke 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 |
| Medical nutrition therapy  The plan covers nutritional diagnostic therapy and counseling services to help you manage a medical condition (such as kidney disease).  [List any additional benefits offered.] | $0 |
| Medically necessary non-emergency transportation  The plan covers transportation you need for medical reasons other than emergencies. | $0 |
| **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 cover the following drugs:   * Drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services * Drugs you take using DME (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 postmenopausal 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 also explains the rules you must follow to have prescriptions covered.  [*Plans must insert if applicable:* **Chapter 6** [plans may insert reference, as applicable] **explains your portion of the cost for your outpatient drugs through our plan.**] | $0 |
| [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Nursing facility care | $0 |
| Obesity screening and therapy to keep weight down  The plan covers 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 [insert as appropriate: physician **or** provider] to find out more.  [List any additional benefits offered.] | $0 |
| Orthotic services  The plan covers braces (non-dental) and other mechanical or molded devices to support or correct the form or function of the human body. | $0 |
| [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient behavioral health services  The plan covers mental health services provided by the following providers:   * 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-qualified mental health care professional as allowed under applicable state laws.   The plan covers services including:   * individual, group, and couples/family treatment * medication visit * diagnostic evaluation * family consultation * case consultation * psychiatric consultation on an inpatient medical unit * inpatient-outpatient bridge visit * acupuncture treatment * opioid replacement therapy * ambulatory detoxification (Level II.d) * psychological testing   [Plans should include any limitations that apply for these services, (e.g., number of visits)] [List any additional benefits offered.] | $0 |
| Outpatient diagnostic tests and therapeutic services and supplies  The plan covers services including:   * 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 * [Modify as necessary if the plan begins coverage with an earlier pint:] Blood. The plan will pay for storage and administration * Other outpatient diagnostic tests   [Plans can include other covered tests as appropriate.] | $0 |
| Outpatient drugs  Please read Chapter 5 for information on drug benefits, and Chapter 6 for information on what you pay for drugs. | $0 |
| Outpatient hospital services  The plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan covers services including:   * 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 Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan covers physical therapy, occupational therapy, and speech therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
| Outpatient substance use disorder services  [Describe the plan’s benefits for outpatient substance use disorder services other than those included in the table below of diversionary behavioral health services.] | $0 |
| Outpatient surgery  The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
| **Oxygen and respiratory therapy equipment**  The plan covers services including oxygen systems, refills, and oxygen therapy equipment rental. | $0 |
| Personal care attendant services  The plan covers personal care attendant services to assist you with activities of daily living and instrumental activities of daily living if you qualify. These include, for example:   * bathing * meal preparation and eating * dressing and grooming * medication management * moving from place to place * toileting * transferring * laundry * housekeeping   These may also include Personal Assistance Services, such as cueing and monitoring.  You can hire a worker yourself or use an agency to hire one for you.  A worker can help you with hands-on tasks. The plan may also pay for a worker to help you, even if you do not need hands-on help. Your Care Team will work with you to decide if that service is right for you and will be in your individualized Personal Care Plan. | $0 |
| Physician/provider services, including doctor’s office visits  The plan covers 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 [insert as appropriate: physician or 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 the following: * 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 |
| **Physician, nurse practitioner, and nurse midwife services**  The plan covers physician, nurse practitioner, and nurse midwife services. These include, for example:   * office visits for primary care and specialists * OB/GYN and prenatal care * diabetes self-management training * medical nutritional therapy * tobacco-cessation services | $0 |
| Podiatry services  The plan covers 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 |
| Prostate-cancer screening exams  The plan covers the following services:   * A digital rectal exam * A prostate specific antigen (PSA) test   [List any additional benefits offered.] | $0 |
| [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Prosthetic devices and related supplies  Prosthetic devices replace all or part of a body part or function. The plan covers services including:   * 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)   In addition, the plan covers some supplies related to prosthetic devices. The plan also covers repairing or replacing 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 cover prosthetic dental devices. | $0 |
| Pulmonary-rehabilitation services  The plan covers 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 |
| Renal (Kidney) disease services and supplies  The plan covers 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 covers some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart. | $0 |
| Sexually transmitted infections (STIs) screening and counseling  The plan covers screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care [insert as appropriate: physician or provider] must order the tests.  The plan also covers face-to-face, high-intensity behavioral counseling sessions. The plan covers these counseling sessions as a preventive service only if they are given by a primary care [insert as appropriate: physician or 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 hospital stay is required.]  The plan covers services including:   * 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 [modify as necessary if the plan begins coverage with an earlier pint:] * The plan will pay for whole blood and packed red cells. * The plan will pay for all other parts of blood, beginning with the first pint used. * 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   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 | $0 |
| Transitional Living Services Program  The plan covers services provided by a transitional living services provider for members who qualify. These services are provided in a residential setting and may include the following:   * Personal care attendant services * On-site 24-hour nurse oversight * Meals * Skills trainers * Assistance with Instrumental Activities of Daily Living (e.g., laundry, shopping, cleaning) | $0 |
| Urgently needed care  Urgently needed care is care given to treat the following:   * a non-emergency (does not include routine primary care services) * a sudden medical illness * an injury * 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 offered as a supplemental benefit outside of the U.S. and its territories.] | $0 |
| [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Vision care  The plan will pay for the following:   * Comprehensive eye exams * Vision training * Eye glasses * Contact lenses and other visual aids   The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.  For people at high risk of glaucoma, the plan covers glaucoma screenings.  [Plans should modify this description if the plan offers more than is covered by Medicare.] The plan covers glasses or contact lenses after cataract surgery when the doctor inserts an intraocular lens.  [Also list any additional benefits offered, such as supplemental vision exams or glasses.] | $0 |
| “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. | $0 |
| Wellness visit  The plan covers wellness checkups. This is to make or update a prevention plan. | $0 |

In addition to the general services, our plan also covers community-based behavioral health care services. These are sometimes called “diversionary behavioral health services.” These are services that you may be able to use instead of going to the hospital or a facility for some behavioral health needs. Your Care Team will work with you to decide if these services are right for you and will be in your individualized Personal Care Plan.

| **Community-based (diversionary) behavioral health care services that our plan covers** | **What you must pay** |
| --- | --- |
| These services include the following:   * Community crisis stabilization * Community Support Program (CSP) * Partial hospitalization * “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.]   * Acute treatment services for substance use disorders * Clinical support services for substance use disorders * Additional substance use disorder services, such as:   + Clinically managed population-specific high intensity residential   + Enhanced residential rehabilitation for dually diagnosed individuals   + Residential rehabilitation   + Recovery coaching   + Recovery support navigator * Psychiatric day treatment * Intensive outpatient program * Structured outpatient addiction program * Program of Assertive Community Treatment (PACT) * Emergency Services Program (ESP) | $0 |

Our plan also covers community-based services to promote wellness, recovery, self-management of chronic conditions, and independent living. These services may also help you stay out of the hospital or nursing facility. Your Care Team will work with you to decide if these services are right for you and will be in your individualized Personal Care Plan.

| **Community-based services that our plan covers** | **What you must pay** |
| --- | --- |
| **Care transitions assistance**  The plan pays covers services to help with transitions between care settings for members who qualify. These services may include the following:   * coordination of information between your providers * follow-up after your inpatient or facility stay * education about your health condition * referrals | $0 |
| **Community health workers**  The plan covers services provided by community health workers, which may include the following:   * health education in your home or community * getting you the services you need * counseling, support and screenings   Services from a community health worker means that you’ll be getting help from someone who will advocate for you and who understands your culture, needs and preferences | $0 |
| **Day services**  The plan covers structured day activities at a program to help you learn skills that you need to live as independently as possible in the community. Skills are designed to meet your needs, and may include the following:   * daily living skills * communication training * prevocational skills * socialization skills | $0 |
| **Home care services**  The plan covers home care services provided in your home or community if you qualify. These services may include the following:   * a worker to help you with household talks * a worker to help you with your everyday tasks and personal care. Assistance can be hands-on, prompting, or supervising these tasks. * training or activities to improve your community living skills and help you advocate for yourself | $0 |
| **Home modifications**  The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, welfare and safety or make you more independent in your home. Modifications may include the following:   * ramps * grab-bars * widening of doorways * special systems for medical equipment   [*Plans may list exclusions or limitations that may apply.*] | $0 |
| **Medication management**  The plan covers medication management services from a support worker if you qualify. The support worker will help you take your prescription and over-the-counter medications. The service may include the following:   * reminding you to take your medication * checking the medication package * watching you take your medication * writing down when you take your medication * opening medications and reading the labels for you | $0 |
| **Nonmedical transportation**  The plan covers transportation to community services and activities that help you stay independent and active in your community. | $0 |
| **Peer support/counseling/navigation**  The plan covers training, instruction, and mentoring services if you qualify. These services will help you to advocate for yourself and participate in your community. You may get these services from a peer or in small groups. | $0 |
| **Respite care**  The plan covers respite-care services if your primary caregiver needs relief or is going to be unavailable for a short-term basis. These services can be provided in an emergency or be planned in advance. If planned in advance, services might be in your home, or during a short-term placement in adult foster care, adult day health, nursing facility, assisted living, rest home, or hospital. | $0 |

# Our plan’s visitor or traveler benefits

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

If you are out of the plan’s service area for more than six months at a time, we would usually 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 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, Medicaid, or a State Agency.

## F1. Hospice Care

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

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 hospice or non-hospice care, you should call your Care Coordinator to help 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.]

## F2. State Agency Services

**Psychosocial Rehabilitation and Targeted Case Management**

If you are getting Psychosocial Rehabilitation from the Department of Mental Health or Targeted Case Management from the Department of Mental Health or Department of Developmental Services, your services will continue to be provided directly from the state agency. However, <plan name> will assist in coordinating with these providers as a part of your overall individualized Personal Care Plan.

**Rest Home Room and Board**

If you live in a rest home and join One Care, the Department of Transitional Assistance will continue to be responsible for your room and board payments.

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

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

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

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should 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 Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid or under a state’s demonstration, or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plans may also add exclusions as needed.]

* Services that are not medically necessary according to the standards of Medicare and MassHealth.
* 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.
* [Plans should delete this if the State allows for this:] Fees charged by your immediate relatives or members of your household, except as allowed for personal care assistance or adult foster 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.
* 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 malformed. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* 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.
* [Plans should delete this if supplemental:] Radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids.
* Reversal of sterilization procedures and nonprescription contraceptive supplies.
* Naturopath services (the use of natural or alternative treatments).