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 should reference the stand alone Member Handbook and Provider Manual developed specifically for Nursing Facilities, which were incorporated into managed care in Texas effective March 1, 2015.*]

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

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

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

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

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

If you need help understanding what services are covered, call your Service Coordinator and/or Member Services at <toll-free number>. [Plans should include a phone number or other contact information.]

# B. Rules against providers charging you for services

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

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

# C. Our plan’s Benefits Chart

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

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

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

* Your Medicare and Texas Medicaid covered services must be provided according to the rules set by Medicare and Texas Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you 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. [Plans should add the state-specific definition of “medically necessary” as appropriate *and ensure that it is updated and used consistently throughout member material models*.]
* [Insert if applicable: You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.]
* [Plans should describe how a member can obtain services.]
* [Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can see someone that is not your PCP or use other providers in the plan’s network. This is called a referral. Chapter 3 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.]
* [Insert if applicable: 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.]

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

[Instructions on completing the Benefits Chart:

* For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.
* Include the following where appropriate: You should talk to your provider and get a referral.
* Plans must include any services provided in excess of the Medicare and Texas Medicaid requirements. Preventive services must be identified with the apple icon.
* Plans should clearly indicate which benefits are subject to prior authorization. (This can be done with asterisks, footnotes, bold type, or italic type. Plans should select one method of indication throughout the document; do not use multiple methods.)
* Plans may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Benefits Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* Plans must describe any restrictive policies, limitations, or monetary limits that might affect a beneficiary’s access to services within the chart.
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans should include all non-waiver LTSS in the chart in alphabetical order.
* All HCBS waiver services should be appended to the end of the chart.
* Plans should include any other services (non-capitated) they can help members get.
* 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.*]

# D. The Benefits Chart

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

| Services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Preventative services | 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 |
|  | [Plans should modify this section to reflect Texas Medicaid or plan-covered supplemental benefits as appropriate.]  Alcohol misuse screening and counseling  The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) 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 |
| Preventative services | Annual wellness visit  If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months.  **Note:** You cannot have your first annual checkup within  12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. | $0 |
|  | Behavioral health services  The plan will pay for the following services:   * Mental health targeted case management * Mental health rehabilitative services | $0 |
| Preventative services | Bone mass measurement  The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.  The plan will pay for the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.  [List any additional benefits offered.] | $0 |
| Preventative services | Breast cancer screening (mammograms)  The plan will pay for the following services:   * One baseline mammogram between the ages of 35 and 39 * One screening mammogram every 12 months for women age 40 and older * Clinical breast exams once every 24 months   [List any additional benefits offered.] | $0 |
|  | Cardiac (heart) rehabilitation services  The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s [insert as appropriate: referral **or** order].  The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
| Preventative services | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan pays for one visit a year 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, or * give you tips to make sure you are eating well.   [List any additional benefits offered.] | $0 |
| Preventative services | Cardiovascular (heart) disease testing  The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0 |
| Preventative services | Cervical and vaginal cancer screening  The plan will pay for the following services:   * For all women: Pap tests and pelvic exams once every 24 months * For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months * For women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months   [List any additional benefits offered.] | $0 |
|  | Chiropractic services  The plan will pay for the following services:   * Adjustments of the spine to correct alignment   [List any additional benefits offered. Also list any restrictions, such as the maximum number of visits.] | $0 |
| Preventative services | Colorectal cancer screening  For people 50 and older, the plan will pay for the following services:   * Flexible sigmoidoscopy (or screening barium enema) every 48 months * Fecal occult blood test, every 12 months * Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months * DNA based colorectal screening every 3 years   For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months  For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).  [List any additional benefits offered.] | $0 |
| Preventative services | Counseling to stop smoking or tobacco use  If you use tobacco but do not have signs or symptoms of tobacco-related disease:   * The plan will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * The plan will pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.   The plan also offers tobacco cessation counseling for pregnant women.  [List any additional benefits offered.] | $0 |
|  | [Plans should include this row if applicable. Add the apple icon if listing only preventive services.]  Dental services  <Plan name> will pay for the following services:  [List any additional (non-waiver) benefits offered, such as routine dental care, dental X-rays, and cleanings.] | $0 |
| Preventative services | Depression screening  The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  [List any additional benefits offered.] | $0 |
| Preventative services | Diabetes screening  The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:   * High blood pressure (hypertension) * History of abnormal cholesterol and triglyceride levels (dyslipidemia) * Obesity * History of high blood sugar (glucose)   Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months  [List any additional benefits offered.] | $0 |
| Preventative services | Diabetic self-management training, services, and supplies  The plan will pay for the following services for all people who have diabetes (whether they use insulin or not):   * Supplies to monitor your blood glucose, including the following: * A blood glucose monitor * Blood glucose test strips * Lancet devices and lancets * Glucose-control solutions for checking the accuracy of test strips and monitors * For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: * One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** * One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)   The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.   * The plan will pay for training to help you manage your diabetes, in some cases.   [List any additional benefits offered.] | $0 |
|  | [Plans that cover durable medical equipment as a Texas Medicaid benefit should modify the following description if necessary.]  Durable medical equipment (DME) and related supplies  (For a definition of “Durable medical equipment (DME),” see Chapter 12 [plans may insert reference, as applicable] of this handbook.)  The following items are covered:   * Wheelchairs * Crutches * Powered mattress systems * Diabetic supplies * Hospital beds ordered by a provider for use in the home * Intravenous (IV) infusion pumps * Speech generating devices * Oxygen equipment and supplies * Nebulizers * Walkers   Other items may be covered.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Texas Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  [Plans that limit the DME brands and manufacturers that you will cover, insert the following (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.): With this Member Handbook, we sent you <plan name>’s list of DME. The list tells you the brands and makers of DME that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  **This benefit is continued on the next page** | $0 |
|  | **Durable medical equipment (DME) and related supplies (continued)**  Generally, <plan name> covers any DME covered by Medicare and Texas 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 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.   Medical services performed out of the country are not covered. | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plans should insert information as needed to accurately describe emergency care benefits:(e.g. you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.)]. |
|  | [Plans should modify this as necessary.]  Family planning services  The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office.  The plan will pay for the following services:   * Family planning exam and medical treatment * Family planning lab and diagnostic tests * Family planning methods (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 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 |
| Preventative services | [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. Plans should include information on enhanced disease management, tele-monitoring, web/phone-based technology and counseling services.] | $0 |
|  | [Plans that cover hearing services as a Texas Medicaid benefit should modify the following description if necessary. Add the apple icon if listing only preventive services.]  Hearing services  The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  The plan will also pay for hearing aids for one ear every five years.  [List any additional benefits offered, such as routine hearing exams, additional hearing aid benefits, 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.] | [List copays.] |
| Preventative services | HIV screening  The plan pays for one HIV screening exam every 12 months for people who:   * ask for an HIV screening test, **or** * are at increased risk for HIV infection.   For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.  [List any additional benefits offered.] | $0 |
|  | Home health agency care  [Plans should modify this section to reflect Texas Medicaid or plan-covered supplemental benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.  The plan will pay for the following services, and maybe other services not listed here:   * Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies | $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 prognosis 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   **This benefit is continued on the next page** |  |
|  | **Hospice care (continued)**  **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].   **Note:** If you need non-hospice care, you should call your service coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should replace the term “service 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.] |  |
| Preventative services | Immunizations  The plan will pay for the following services:   * Pneumonia vaccine * Flu shots, once a year, in the fall or winter * Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B * Other vaccines if you are at risk and they meet Medicare Part B coverage rules   The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plans 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 the following services, and maybe other services not listed here:   * Semi-private room (or a private room if it is medically necessary) * Meals, including special diets * Regular nursing services * Costs of special care units, such as intensive care or coronary care units * Drugs and medications * Lab tests * X-rays and other radiology services * Needed surgical and medical supplies   This benefit is continued on the next page |  |
|  | Inpatient hospital care (continued)   * Appliances, such as wheelchairs * Operating and recovery room services * Physical, occupational, and speech therapy * Inpatient substance abuse services * 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 beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. * The plan will pay for all other parts of blood beginning with the first pint used. * Physician services * In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.   If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. 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.] | $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 mental health care  The plan will pay for mental health care services that require a hospital stay. [List days covered and restrictions, such as a 190-day lifetime limit for inpatient services in a psychiatric hospital, unless the 190-day limit does not apply due to Texas Medicaid wrap-around coverage. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.] | $0 |
|  | [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  If your inpatient stay is not reasonable and necessary, the plan will not pay for it.  However, in some cases the plan will pay for services you get while you are in the hospital or a nursing facility. The plan will pay for the following services, and maybe other services not listed here:   * Doctor services * Diagnostic tests, like lab tests * X-ray, radium, and isotope therapy, including technician materials and services * Surgical dressings * Splints, casts, and other devices used for fractures and dislocations   This benefit is continued on the next page |  |
|  | Inpatient services covered during a non-covered inpatient stay (continued)   * 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 |
|  | Kidney disease services and supplies  The plan will pay for the following services:   * Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. * Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable] * Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care * Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments * Home dialysis equipment and supplies * Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply   Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart. | $0 |
| Preventative services | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:   * Are aged 55-77, **and** * Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** * Have smoked at least 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 |
| Preventative services | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [insert as appropriate: referred **or** ordered] by your doctor.  The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s [insert as appropriate: referral **or** order]. A doctor must prescribe these services and renew the [insert as appropriate: referral **or** order] each year if your treatment is needed in the next calendar year.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | **Medicare Diabetes Prevention Program (MDPP)**  The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:   * long-term dietary change, **and** * increased physical activity, **and** * ways to maintain weight loss and a healthy lifestyle. | $0 |
|  | Medicare Part B prescription drugs  These drugs are covered under Part B of Medicare. <Plan name> will pay for the following drugs:   * Drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services * Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan * Clotting factors you give yourself by injection if you have hemophilia * Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant * Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself * Antigens * Certain oral anti-cancer drugs and anti-nausea drugs * Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) * IV immune globulin for the home treatment of primary immune deficiency diseases   Chapter 5 [plans may insert reference, as applicable] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [plans may insert reference, as applicable] explains what you pay for your outpatient prescription drugs through our plan**.** | $0 |
|  | [Plans should modify this section to reflect Texas Medicaid or plan-covered supplemental benefits as appropriate.]  Nursing facility care | $0 |
| Preventative services | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care [insert as appropriate: physician **or** provider] to find out more.  [List any additional benefits offered.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  The plan will pay for the following services, and maybe other services not listed here:   * X-rays * Radiation (radium and isotope) therapy, including technician materials and supplies * Surgical supplies, such as dressings * Splints, casts, and other devices used for fractures and dislocations * Lab tests * [Modify as necessary if the plan begins coverage with an earlier pint:] Blood, beginning with the fourth pint of blood that you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. The plan will pay for storage and administration beginning with the first pint of blood you need. * Other outpatient diagnostic tests   [Plans can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will pay for the following services, and maybe other services not listed here:   * Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery * Labs and diagnostic tests billed by the hospital * Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it * X-rays and other radiology services billed by the hospital * Medical supplies, such as splints and casts * Preventive screenings and services listed throughout the Benefits Chart * Some drugs that you can’t give yourself   [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect Texas Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will pay for mental health services provided by:   * a state-licensed psychiatrist or doctor, * a clinical psychologist, * a clinical social worker, * a clinical nurse specialist, * a nurse practitioner, * a physician assistant, **or** * any other Medicare-qualified mental health care professional as allowed under applicable state laws.   The plan will pay for the following services, and maybe other services not listed here:   * Clinic services [Plans should include any Texas Medicaid limitations that apply (e.g., number of visits)] * Day treatment [Plans should include any Texas Medicaid limitations that apply (e.g., number of visits)] * Psychosocial rehab services [Plans should include any Texas Medicaid limitations that apply (e.g., number of visits)]   [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect Texas Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan will pay for physical therapy, occupational therapy, and speech therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | Outpatient substance abuse services  [Describe the plan’s benefits for outpatient substance abuse services.] | $0 |
|  | Outpatient surgery  The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | [Plans should modify this section to reflect Texas Medicaid or plan-covered supplemental benefits as appropriate.]  Partial hospitalization services  Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor’s or therapist’s office. It can help keep you from having to stay in the hospital.  [Network plans that do not have an in-network community mental health center may add: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | **Personal Assistance Services**  The plan covers personal assistance with activities of daily living.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Grooming * Eating * Bathing * Dressing and personal hygiene * Functional living tasks / assistance with planning * Preparing meals * Transportation, or assistance in securing transportation * Assistance with ambulation and mobility * Reinforcement of behavioral support or specialized therapies activities; and * Assistance with medications   These services can be self-directed if you choose. This option allows you or your legally authorized representative to be the employer of some of your service providers and to direct the delivery of program services. | $0 |
|  | Physician/provider services, including doctor’s office visits  The plan will pay for the following services:   * Medically necessary health care or surgery services given in places such as: * physician’s office * certified ambulatory surgical center * hospital outpatient department * Consultation, diagnosis, and treatment by a specialist * Basic hearing and balance exams given by your [insert as applicable: primary care [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: * 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 |
| Preventative services | Prostate cancer screening exams  For men age 50 and older, the plan will pay for the following services once every 12 months:   * A digital rectal exam * A prostate specific antigen (PSA) test   [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect Texas 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, and maybe other devices not listed here:   * Colostomy bags and supplies related to colostomy care * Pacemakers * Braces * Prosthetic shoes * Artificial arms and legs * Breast prostheses (including a surgical brassiere after a mastectomy)   The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.  The plan offers some coverage after cataract removal or cataract surgery. See “Vision care” later in this section [plans may insert reference, as applicable] for details.  [Plans that pay for prosthetic dental devices, delete the following sentence:] The plan will not pay for prosthetic dental devices. | $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 |
| Preventative services | Sexually transmitted infections (STIs) screening and counseling  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care [insert as appropriate: physician **or** provider] must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.  The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care [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 will pay for the following services, and maybe other services not listed here:   * A semi-private room, or a private room if it is medically necessary * Meals, including special diets * Nursing services * Physical therapy, occupational therapy, and speech therapy * Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors * Blood, including storage and administration [modify as necessary if the plan begins coverage with an earlier pint:] * The plan will pay for whole blood and packed red cells beginning with the fourth pint of blood you need. You must pay for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. * 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   **This benefit is continued on the next page** | $0 |
|  | Skilled nursing facility care (SNF) (continued)  You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:   * A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) * A nursing facility where your spouse lives at the time you leave the hospital |  |
|  | Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency, **or** * a sudden medical illness, **or** * an injury, **or** * a condition that needs care right away.   If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.  Medical services performed out of the country are not covered. | $0 |
| Preventative services | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Medicare does not cover regular eye exams for glasses or contacts.  For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include:   * people with a family history of glaucoma, * people with diabetes * African-Americans who are age 50 and older, and * Hispanic Americans who are 65 or older.   The plan covers one eye exam every two years.  [Plans should modify this description if the plan offers more than is covered by Medicare and Texas Medicaid.] The plan will pay for one pair of glasses or contact lenses every two years. | $0 |
| Preventative services | “Welcome to Medicare” Preventive Visit  The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:   * a review of your health, * education and counseling about the preventive services you need (including screenings and shots), and * referrals for other care if you need it.   **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

# E. Our home and community based services

In addition to these general services, our plan also covers home and community-based services. These are services that you may be able to use instead of going to a facility. To get some of these services, you will need to qualify for the home and community-based waiver (the STAR+PLUS Waiver). Your service coordinator will work with you to decide if these services are right for you and will be in your Plan of Care.

[Plans should modify this table to reflect additional plan-covered benefits as appropriate.]

| **Community-based services that our plan covers** | **What you must pay** |
| --- | --- |
| **Adaptive Aids and Medical Supplies**  The plan covers the following devices, controls, appliances, or items that are necessary to address your specific needs, including those necessary for life support up to a $10,000 per year limit.  The plan may pay for the following if medically or functionally necessary, and maybe other items/services not listed here:   * Lifts, including vehicle lifts * Mobility Aids * Positioning Devices * Control switches/pneumatic switches and devices * Environmental control units * Medically necessary supplies * Communication aids (including batteries) * Adaptive/modified equipment for activities of daily living * Safety restraints and safety devices   Case managers can help you get medical supplies or equipment. | $0 |
| **Adult Foster Care**  The plan covers 24-hour living arrangements in a foster home if you have physical, mental, or emotional limitations or if you are unable to continue functioning independently in your own home.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Meal preparation * Housekeeping * Personal care * Nursing tasks * Supervision * Companion services * Daily living assistance * Transportation | $0 |
| **Assisted Living Services**  The plan covers a 24-hour living arrangement for you if you are unable to live independently in your own home.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Host home/companion care that provides you with: * Personal assistance * Functional living tasks * Supervision of your safety and security * Habilitation activities * Supervised living that provides you with: * Personal assistance * Functional living tasks * Supervision of your safety and security * Habilitation activities * Residential support service that provides you with: * Personal assistance * Functional living tasks | $0 |
| **Cognitive Rehabilitation Therapy**  The plan covers services that help you learn or re-learn cognitive skills.  These skills may have been lost or altered as a result of damage to brain cells or brain chemistry. | $0 |
| **Day Habilitation Services**  These services help you with obtaining, retaining, or improving skills necessary to live successfully at home and/or in community-based settings.  They promote independence, personal choice, and achievement of the outcomes identified in your service plan. | $0 |
| **Dental Services**  The plan covers the following services to help preserve your teeth and meet your medical needs up to $5,000 per year. If the services of an oral surgeon are required, you can get an additional $5,000 per year.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Emergency dental treatment * Preventive dental treatment * Therapeutic dental treatment (restoration, maintenance, etc.) * Orthodontic dental treatment | $0 |
| **Emergency Response Services**  The plan covers emergency response services for you through an electronic monitoring system 24 hours a day, seven days a week.  In an emergency, you can press a call button to signal for help. | $0 |
| **Employment Assistance**  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Identifying your employment preferences, job skills, and requirements for a work setting and work conditions * Locating prospective employers offering employment compatible with your identified preferences, skills, and requirements; * Contacting a prospective employer on your behalf and negotiating your employment * Transportation * Participating in service planning team meetings | $0 |
| **Functional Living Task Services**  These services help you with:   * Planning and preparing meals * Transportation, or help in securing transportation * Assistance with ambulation and mobility * Reinforcement of behavioral support or specialized therapies activities * Assistance with medications | $0 |
| **Home-Delivered Meals**  The plan covers hot, nutritious meals that are served in your home. Meals are limited to 1 to 2 per day. | $0 |
| **Minor Home Modifications**  The plan covers minor home modifications to ensure your health, welfare, and safety and to allow you to function with greater independence in your home. The plan will cover up to $7,500 over the course of your lifetime and will also cover up to $300 each year for repairs.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Installation of ramps and grab bars * Widening of doorways * Modifications of kitchen and bathroom facilities, and * Other specialized accessibility adaptations | $0 |
| **Nursing Services**  The plan covers the treatment and monitoring of your medical conditions, especially if you have chronic conditions that require specific nursing tasks. | $0 |
| **Occupational Therapy**  The plan covers occupational therapy for you, which provides assessment and treatment by a licensed occupational therapist.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Screening and assessment * Development of therapeutic treatment plans * Direct therapeutic intervention * Assistance, and training with adaptive aids and augmentative communication devices * Consulting with and training other service providers and family members * Participating on the service planning team, when appropriate | $0 |
| **Personal Assistance Services**  The plan covers personal assistance with activities of daily living.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Grooming * Eating * Bathing * Dressing and personal hygiene * Functional living tasks / assistance with planning * Preparing meals * Transportation or assistance in securing transportation * Assistance with ambulation and mobility * Reinforcement of behavioral support or specialized therapies activities; and * Assistance with medications | $0 |
| **Physical Therapy**  The plan covers physical therapy, assessments, and treatments by a licensed physical therapist.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Screening and assessment * Development of therapeutic treatment plans * Direct therapeutic intervention * Assistance and training with adaptive aids/augmentative communication devices * Consulting with and training other service providers and family members * Participating on the service planning team, when appropriate | $0 |
| **Respite Care**  The plan may pay for the following services if medically or functionally necessary up to 30 visits a year, and maybe other services not listed here:   * Personal assistance * Habilitation activities * Community activities * Leisure activities * Supervision of your safety and security * Development of socially valued behaviors * Development of daily living skills   Respite care is provided to ensure your comfort, health, and safety. It may be provided in the following locations: your home or place of residence; adult foster care home; Texas Medicaid certified nursing facility; and an assisted living facility. | $0 |
| **Speech, Hearing, and Language Therapy**  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Screening and assessment * Development of therapeutic treatment plans * Direct therapeutic intervention * Assistance/training with adaptive aids and augmentative communication devices * Consulting with and training other service providers and family members * Participating on the service planning team, when appropriate | $0 |
| **Support Consultation**  The plan covers optional support consultation provided by a chosen certified support advisor.  This advisor will assist you in learning about and performing employer responsibilities.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Recruiting, screening, and hiring workers * Preparing job descriptions * Verifying employment eligibility and qualifications, and other documents required to employ an individual * Managing workers * Other professional skills as needed | $0 |
| **Supported Employment**  The plan covers supported employment, which is provided to you at your place of employment if:   * You need the support services to maintain employment due to a disability; * You are paid minimum wage (or more) for the work performed; and * Your place of employment is competitive and integrated.   The plan also covers transportation to and from your worksite, and supervision and training to you beyond what an employer would ordinarily provide. | $0 |
| **Transitional Assistance Services**  The plan covers one transition from a nursing facility to a home in the community, up to a $2,500 limit.  The plan may pay for the following services if medically or functionally necessary, and maybe other services not listed here:   * Payment of security deposits required to lease an apartment or home * Set-up fees or deposits to establish utility services for the home, including telephone, electricity, gas, and water * Purchase of essential furnishings for the apartment or home, including table, chairs, window blinds, eating utensils, food preparation items, and bath linens * Payment of moving expenses required to move into or occupy the home or apartment; and * Payment for services to ensure your health in the apartment or home, such as pest eradication, allergen control, or a one-time cleaning before occupancy | $0 |

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

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

# G. 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 Texas Medicaid fee-for-service, as appropriate*.]

The following services are not covered by <plan name> but are available to you through Medicare or Texas Medicaid.

## G1. Hospice Care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Hospice programs provide members and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. 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 and any Medicare Part A or B services. You pay nothing for these services.

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

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

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

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

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

## G2. Nonemergency Medical Transportation Services

These are transportation services to get you to medical appointments, like the doctor, dentist or drug store.

## G3. Pre-Admission Screening and Resident Review (PASRR)

This is a program to ensure members are not inappropriately placed in nursing homes. This requires that members (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) get the services they need in those settings.

# H. Benefits not covered by <plan name>, Medicare, or Texas 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 Texas Medicaid will not pay for them either.

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

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

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

[The services listed in the remaining bullets are excluded from Medicare’s and Texas Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Texas Medicaid or under a State’s demonstration, or have become covered due to a Medicare or Texas 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 considered not “reasonable and necessary,” according to the standards of Medicare and Texas 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 pays for it.
* A private room in a hospital, except when it is medically necessary.
* Private duty nurses.
* Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
* Full-time nursing care in your home.
* [Plans should delete this if State allows for this:] Homemaker services, including basic household assistance, light cleaning or making meals.
* [Plans should delete this if State allows for this:] Fees charged by your immediate relatives or members of your household.
* Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
* Cosmetic surgery or other cosmetic work, unless it 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.
* [Plans should delete this if dental services are supplemental benefits:] Regular dental care, such as cleanings, fillings or dentures. However, dental care required to treat illness or injury may be covered as inpatient or outpatient care.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* Routine foot care, except for the limited coverage provided according to Medicare 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.
* Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
* [*Plans should delete any of the following if covered as supplemental benefits:*] Radial keratotomy, LASIK surgery, 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 the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.