Chapter 4: Benefits Chart

**Introduction**

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

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "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.]

Table of Contents

[A. Your covered services 2](#_Toc11837376)

[B. Rules against providers charging you for services 2](#_Toc11837377)

[C. Our plan’s Benefits Chart 3](#_Toc11837378)

[D. The Benefits Chart 6](#_Toc11837379)

[E. Our plan’s visitor or traveler benefits 52](#_Toc11837380)

[F. Benefits covered outside of <plan name> 52](#_Toc11837381)

[F1. Hospice care 52](#_Toc11837382)

[F2. Services covered by the Prepaid Inpatient Health Plan (PIHP) 53](#_Toc11837383)

[G. Benefits not covered by <plan name>, Medicare, or Michigan Medicaid 53](#_Toc11837384)

# Your covered services

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

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. The only exceptions are that you pay any:

* Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services.
* Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting <https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html>.

If you need supports and services related to a behavioral health condition, intellectual or developmental disability, or a substance use disorder, please work with your Care Coordinator to get services provided through the Prepaid Inpatient Health Plan (PIHP). You will also get a PIHP Member Handbook which will further explain the PIHP eligibility and covered specialty services.

Depending on eligibility criteria, some items, supplies, supports and services may be offered through our plan or the PIHP. To ensure our plan and the PIHP are not paying for the same items, supplies, supports or services, your Care Coordinator can help you get what you need from either our plan or the PIHP. Services from the PIHP have different eligibility or medical necessity criteria. See Section F in this chapter [plans may insert reference, as applicable] and the PIHP handbook for more information.

If you need help understanding what services are covered, call your Care Coordinator and/or Member Services at <toll-free number>, <days and hours of operation>.

# Rules against providers charging you for services

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

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

# Our plan’s Benefits Chart

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

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections:

[Plans that offer HCBS services only to enrollees receiving waiver services, insert:

* General Services
* Offered to all enrollees
* Home and Community-Based Services (HCBS) Waiver
* Offered only to enrollees who:
* require nursing facility level of care but are not residing in a nursing facility, and
* have a need for covered waiver services]

[Plans that offer HCBS services to **all** enrollees, insert:

* General Services
* Home and Community-Based Services (HCBS)]

[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.** You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below. The only exceptions are that you pay any Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services or any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting <https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html>.

* Your Medicare and Michigan Medicaid covered services must be provided according to the rules set by Medicare and Michigan 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.]
* You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.
* You have a primary care provider (PCP) that is providing 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.
* Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization are marked in the Benefits Chart [insert as appropriate: by an asterisk (\*) **or** by a footnote **or** in bold type **or** in italic type]. [Insert if applicable: In addition, you must get prior authorization for the following services that are not listed in the Benefits Chart: [insert list].]
* [Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI)”* in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:
  + [*List all applicable chronic conditions here.*]
  + [If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]

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

* 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 Michigan 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 only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)
* 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 member’s access to services within the chart.
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans should include all non-waiver LTSS in the chart in alphabetical order.
* All HCBS waiver services should be appended to the end of the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed.
* Plans offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
  + Deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the “Uniformity Flexibility” benefits for which they are eligible.
  + Update the Benefits Chart to include details, as applicable, about the additional supplemental benefits being offered.]

# The Benefits Chart

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

| General Services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Red apple appears on the left side of the table next to preventive 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 |
|  | Adaptive Medical Equipment and Supplies  The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily livingor to perceive, control, or communicate with the environment in which you live. Services might include:   * shower chairs/benches * lift chairs * raised toilet seats * reachers * jar openers * transfer seats * bath lifts/room lifts * swivel discs * bath aids such as long handle scrubbers   **This benefit is continued on the next page** | $0 |
|  | Adaptive Medical Equipment and Supplies (continued)   * telephone aids * automated/telephone or watches that assist with medication reminders * button hooks or zipper pulls * modified eating utensils * modified oral hygiene aids * modified grooming tools * heating pads * sharps containers * exercise items and other therapy items * voice output blood pressure monitor * nutritional supplements such as Ensure   [List any additional benefits offered.] |  |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Alcohol misuse screening and counseling  The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. 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 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 |
| Red apple appears on the left side of the table next to preventive services | Annual wellness visit  If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months.  **Note**: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. | $0 |
| Red apple appears on the left side of the table next to preventive services | Bone mass measurement  The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.  The plan will pay for the services once every 24 months or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.  [List any additional benefits offered.] | $0 |
| Red apple appears on the left side of the table next to preventive 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 |
| Red apple appears on the left side of the table next to preventive services | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:   * discuss aspirin use, * check your blood pressure, or * give you tips to make sure you are eating well.   [List any additional benefits offered.] | $0 |
| Red apple appears on the left side of the table next to preventive services | Cardiovascular (heart) disease testing  The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0 |
| Red apple appears on the left side of the table next to preventive services | Cervical and vaginal cancer screening  The plan will pay for the following services:   * For all women: Pap tests and pelvic exams once every 24 months * For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months * For women who have had an abnormal Pap test within the last 3 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 * Diagnostic x-rays | $0 |
| Red apple appears on the left side of the table next to preventive 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 |
|  | Community Transition Services  The plan will pay for one-time expenses for you to transition from a nursing home to another residence where you are responsible for your own living arrangement. You must have resided in the nursing home for ninety (90) consecutive days to get this service. Covered services may include:   * housing or security deposits * utility hook-ups and deposits (excludes television and internet) * furniture (limited) * appliances (limited) * moving expenses (excludes diversion or recreational devices) * cleaning including pest eradication, allergen control, and over-all cleaning   This service does not include ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes. Coverage is limited to once per year. | $0 |
| Red apple appears on the left side of the table next to preventive services | Counseling to stop smoking or tobacco use  If you use tobacco but do not have signs or symptoms of tobacco-related disease:   * The plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * The plan will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits.   [List any additional benefits offered.] | $0 |
|  | Dental services  <Plan name> will pay for the following services:   * Examinations and evaluations are covered once every six months * Cleaning is a covered benefit once every six months * Silver diamine fluoride treatment is covered with a maximum of six applications per lifetime * X-rays * Bitewing x-rays are a covered benefit only once in a 12-month period * A panoramic x-ray is a covered benefit once every five years * A full mouth or complete series of x-rays is a covered benefit once every five years * Fillings * Tooth extractions * Complete or partial dentures are covered once every five years   [List any plan-covered supplemental benefits offered.] | $0 |
| Red apple appears on the left side of the table next to preventive services | Depression screening  The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals, which include referrals to your primary care provider or the Prepaid Inpatient Health Plan (PIHP) for further assessment and services.  [List any additional benefits offered.] | $0 |
| Red apple appears on the left side of the table next to preventive services | Diabetes screening  The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:   * High blood pressure (hypertension) * History of abnormal cholesterol and triglyceride levels (dyslipidemia) * Obesity * History of high blood sugar (glucose)   Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.  [List any additional benefits offered.] | $0 |
| Red apple appears on the left side of the table next to preventive services | Diabetic self-management training, services, and supplies  The plan will pay for the following services for all people who have diabetes (whether they use insulin or not):   * Supplies to monitor your blood glucose, including the following: * A blood glucose monitor * Blood glucose test strips * Lancet devices and lancets * Glucose-control solutions for checking the accuracy of test strips and monitors   This benefit is continued on the next page | $0 |
|  | Diabetic self-management training, services, and supplies (continued)   * 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.] |  |
|  | 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   The following items are also covered:   * Breast Pumps * Canes * Commodes * CPAP Device * Enteral Nutrition * Home Uterine Activity Monitor * Incontinence Supplies * Insulin Pump and Supplies   This benefit is continued on the next page | $0 |
|  | Durable medical equipment (DME) and related supplies (continued)   * Lifts, Slings and Seats * Lymphedema Pump * Negative Pressure Wound Therapy * Orthopedic Footwear * Orthotics * Osteogenesis Stimulator * Ostomy Supplies * Parenteral Nutrition * Peak Flow Meter * Pressure Gradient Products * Pressure Reducing Support Surfaces * Prosthetics * Pulse Oximeter * Surgical Dressings * Tracheostomy Care Supplies * Transcutaneous Electrical Nerve Stimulator * Ventilators * Wearable Cardioverter-Defibrillators   **This benefit is continued on the next page** |  |
|  | Durable medical equipment (DME) and related supplies (continued)  Other items may be covered.  Some DME is provided based on Michigan Medicaid policy. Requirements for referral, physician order, and assessment apply along with limitations on replacement and repair.  Other items may be covered, including environmental aids or assistive/adaptive technology. <Plan name> may also cover you learning how to use, modify, or repair your item. Your Integrated Care Team will work with you to decide if these other items and services are right for you and will be in your Plan of Care.  Some items may also be covered through the Prepaid Inpatient Health Plan (PIHP) based on eligibility criteria. These items should be paid for by either our plan or the PIHP, not by both.  [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 Michigan 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 <MMP-specific URL>.  Generally, <plan name> covers any DME covered by Medicare and Michigan Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other health care provider tells us that you need the brand.  This benefit is continued on the next page |  |
|  | Durable medical equipment (DME) and related supplies (continued)  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**   **This benefit is continued on the next page** | $0 |
|  | Emergency care (continued)   * 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 that of your unborn child.   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.)].  [Also identify whether the plan only covers emergency care within the U.S. *and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.*] |  |
|  | [Plans should modify this section 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 |
| Red apple appears on the left side of the table next to preventive services | Health and wellness education programs  [These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. Describe the nature of the programs here.] | $0 |
|  | 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.  For adults aged 21 and older, the plan pays for evaluation and fitting for a hearing aid twice per year and pays for a hearing aid once every five years. Referral and authorization are required.  [List any additional benefits offered.] | $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 and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI),”* which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.] | $0 |
|  | Home health agency care  [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.  The plan will pay for the following services, and maybe other services not listed here:   * Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies * Home health aide when provided with a nursing service | $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   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 [plans may insert reference, as applicable] 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 nothing for these services.   **For drugs that may be covered by <plan name>’s Medicare Part D benefit:**   * Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5 [plans may insert reference, as applicable].   **Note:** If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should 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.] |  |
| Red apple appears on the left side of the table next to preventive services | Immunizations  The plan will pay for the following services:   * Pneumonia vaccine * Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary * Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B * Other vaccines if you are at risk and they meet Medicare Part B or Michigan Medicaid 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 stay: Covered services in a hospital or skill nursing facility (SNF)  [List any restrictions that apply.]  The plan will pay for the following services, and maybe other services not listed here:   * Semi-private room (or a private room if it is medically necessary) * Meals, including special diets * Regular nursing services * Costs of special care units, such as intensive care or coronary care units * Drugs and medications * Lab tests * X-rays and other radiology services * Needed surgical and medical supplies * Appliances, such as wheelchairs * Operating and recovery room services * Physical, occupational, and speech therapy * Inpatient substance use disorder services * Blood, including storage and administration   + The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need.   + 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.   **This benefit is continued on the next page** | $0  You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. |
|  | Inpatient hospital care (continued)  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant.  [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.] |  |
|  | Inpatient behavioral health care  The plan will refer you to the Prepaid Inpatient Health Plan (PIHP) for this service. Refer to Section F in this chapter[plans may insert reference, as applicable] for more information. | $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 |
| Apple icon indicates preventive services. | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:   * Are aged 55-77, **and** * Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** * Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.   After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | 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  [*Plans that will or expect to use Part B step therapy should indicate the Part B drug categories below that will or may be subject to Part B step therapy.*]  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   This benefit is continued on the next page | $0 |
|  | Medicare Part B prescription drugs (continued)   * 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. |  |
|  | Non-emergency medical transportation  The plan will cover transportation for you to travel to or from your medical appointments and the pharmacy if it is a covered service. Types of non-emergency transportation include:   * Wheelchair equipped van * Service car * Taxicab   [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.] | $0 |
|  | Nursing facility care  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 needed * 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 * 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 or significant other lives at the time you leave the hospital * The nursing home where you were living when you enrolled in <plan name>   This service is intended to be long term custodial care and does not overlap with skilled nursing facility care.  You must meet Michigan Medicaid Nursing Facility Level of Care standards to get this service. | When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month.  Patient pay responsibility does not apply to Medicare-covered days in a nursing facility. |
| Red apple appears on the left side of the table next to preventive services | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.  [List any additional benefits offered.] | $0 |
|  | Opioid treatment services  The plan will pay for the following services to treat opioid use disorder:   * Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications * Substance use counseling * Individual and group therapy * Testing for drugs or chemicals in your body (toxicology testing)   [List any additional benefits offered, with the exception of meals and transportation.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  The plan will pay for the following services, and maybe other services not listed here:   * X-rays * Radiation (radium and isotope) therapy, including technician materials and supplies * Surgical supplies, such as dressings * Splints, casts, and other devices used for fractures and dislocations * Lab tests * Blood, beginning with the first pint of blood that you need, including storage and administration. * Other outpatient diagnostic tests   [Plans can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will pay for the following services, and maybe other services not listed here:   * Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services   + Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.”   + Sometimes you can be in the hospital overnight and still be an “outpatient.”   + You can get more information about being an inpatient or an outpatient in this fact sheet: <https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf> * Labs and diagnostic tests billed by the hospital * Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it * X-rays and other radiology services billed by the hospital * Medical supplies, such as splints and casts * Preventive screenings and services listed throughout the Benefits Chart * Some drugs that you can’t give yourself   [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will pay for mental health services provided by a state-licensed:   * psychiatrist or doctor, * clinical psychologist, * clinical social worker, * clinical nurse specialist, * nurse practitioner, * physician assistant, **or** * any other Medicare or Michigan Medicaid-qualified mental health care professional as allowed under applicable state laws.   You may contact the Prepaid Inpatient Health Plan (PIHP), or the plan can refer you to the PIHP for some services.  The plan will pay for the following services, and maybe other services not listed here:   * Clinic services[Plans should include any Michigan Medicaid limitations that apply (e.g., number of visits)] * Day treatment[Plans should include any Michigan Medicaid limitations that apply (e.g., number of visits)] * Psychosocial rehab services[Plans should include any Michigan Medicaid limitations that apply (e.g., number of visits)]   [List any additional benefits offered.] | $0 |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan will pay for physical therapy, occupational therapy, and speech therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | [*Plans should include and describe any plan-covered supplemental benefits in this section, or delete if appropriate.*]  Outpatient substance use disorder services  The plan will refer you to the Prepaid Inpatient Health Plan (PIHP) for these services. Refer to Section F in this chapter [plans may insert reference, as applicable] for more information. | $0 |
|  | Outpatient surgery  The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | [Plans should include any plan-covered supplemental benefits in this section, or delete if appropriate.]  Partial hospitalization services  The plan will refer you to the Prepaid Inpatient Health Plan (PIHP) for these services. Refer to Section F in this chapter [plans may insert reference, as applicable] for more information.  [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 Care Services  The plan will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs), which are tasks like bathing, eating, dressing, and toileting. This service can include instrumental activities of daily living (IADLs) but only when there is also a need for an ADL. IADLs include things like shopping, laundry, meal preparation, medication reminders, and taking you to your appointments. | $0 |
|  | Personal Emergency Response System  The plan covers an electronic in home device that secures help in an emergency.You may also wear a portable “help” button to allow for mobility. The system is connected to your phone and programmed to signal a response center once a “help” button is activated. | $0 |
|  | Physician/provider services, including doctor’s office visits  The plan will pay for the following services:   * Medically necessary health care or surgery services given in places such as: * physician’s office * certified ambulatory surgical center * hospital outpatient department * Consultation, diagnosis, and treatment by a specialist * Basic hearing and balance exams given by your [insert as applicable: primary care provider **or** specialist], if your doctor orders it to see whether you need treatment   **This benefit is continued on the next page** | $0 |
|  | Physician/provider services, including doctor’s office visits (continued)   * [Insert if providing any additional telehealth benefits consistent with 42 CFR §422.135 in the plan’s approved Plan Benefit Package submission: Certain additional telehealth services, including those for [insert specific Part B services the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member]   You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.  [List the available means of electronic exchange used for each Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]]   * [Insert if plan’s service area and providers/locations qualify for telehealth services under Medicare requirements in Section 1834(m) of the Social Security Act: Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner, for patients in rural areas or other places approved by Medicare] * [Only plans that do not cover members who have end-stage renal disease at the time of enrollment or members who develop end-stage renal disease after enrollment, may delete the following: Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis center, or the member’s home] * Telehealth services to diagnose, evaluate, or treat symptoms of a stroke * Virtual check-ins (for example, by phone or video chat) with your provider for 5-10 minutes if:   + you’re not a new patient **and**   + the check-in isn’t related to an office visit in the past 7 days **and**   This benefit is continued on the next page |  |
|  | Physician/provider services, including doctor’s office visits (continued)   * + the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment * Evaluation of video and/or images you sent to your doctor and explanation and follow up by your doctor within 24 hours if:   + you’re not a new patient **and**   + the evaluation isn’t related to an office visit in the past 7 days **and**   + the evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment * Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient * 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 or care delivery models offered.] |  |
|  | 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 |
| Red apple appears on the left side of the table next to preventive 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 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 except for full and partial dentures (see “Dental services”). | $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 |
|  | Respite  You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.  Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.  Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.  Respite is limited to 14 overnight stays per 365 days unless <plan name> approves additional time. | $0 |
| Red apple appears on the left side of the table next to preventive services | Sexually transmitted infections (STIs) screening and counseling  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months 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 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.]  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:   + The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need.   + 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 (SNF) care (continued)  A hospital stay is not required to get SNF care.  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 |  |
|  | Stipend for maintenance costs of a service animal  The plan will pay up to $20 per month for maintenance costs of a service animal if:   * You are receiving personal care services, **and** * You are certified as disabled due to a specific condition defined by the Americans with Disabilities Act, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, **and** * The service animal is trained to meet your specific needs of relative to your disability.   Your service plan must document that the service animal will be used primarily to meet your personal care needs. |  |
|  | **Supervised exercise therapy (SET)**  The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for:   * Up to 36 sessions during a 12-week period if all SET requirements are met * An additional 36 sessions over time if deemed medically necessary by a health care provider   The SET program must be:   * 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) * In a hospital outpatient setting or in a physician’s office * Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD * Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques | $0 |
|  | Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency, **or** * a sudden medical illness, **or** * an injury, **or** * a condition that needs care right away.   If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.  [Include in-network benefits. Also identify whether this coverage is within the U.S. *and its territories or is supplemental world-wide emergency/urgent coverage.*] | $0 |
| Apple icon indicates preventive services. | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  Routine eye examinations are covered once every year.  The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year.  The plan will pay for contact lenses for people with certain conditions.  The plan will pay for basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids.)  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.  For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include:   * people with a family history of glaucoma, * people with diabetes, * African-Americans who are age 50 and older, and * Hispanic Americans who are 65 or older.   [Plans should modify this description if the plan offers more than is covered by Medicare.] The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)  [Also list any additional benefits offered, such as supplemental vision exams or glasses.] | $0 |
| Red apple appears on the left side of the table next to preventive services | “Welcome to Medicare” Preventive Visit  The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:   * a review of your health, * education and counseling about the preventive services you need (including screenings and shots), and * referrals for other care if you need it.   **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

| Home and Community-Based Services (HCBS) Waiver that our plan pays for | | **What you must pay** |
| --- | --- | --- |
|  | Adult Day Program  The plan covers structured day activities at a program of direct care and supervision if you qualify. This service:   * provides personal attention, and * promotes social, physical and emotional well-being | $0 |
|  | Assistive Technology  The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include:   * van lifts * hand controls * computerized voice system * communication boards * voice activated door locks * power door mechanisms * specialized alarm or intercom * assistive dialing device | $0 |
|  | Chore Services  The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include:   * heavy household chores (washing floors, windows, and walls) * tacking loose rugs and tiles * moving heavy items of furniture * mowing, raking, and cleaning hazardous debris such as fallen branches and trees   The plan may cover materials and disposable supplies used to complete chore tasks. | $0 |
|  | Environmental Modifications  The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:   * installing ramps and grab bars * widening of doorways * modifying bathroom facilities * installing specialized electric systems that are necessary to accommodate medical equipment and supplies | $0 |
|  | Expanded Community Living Supports  To get this service, you **must** have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc.  If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself. | $0 |
|  | Fiscal Intermediary Services  The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community-based services authorized in your plan of care. You have the authority to hire the caregiver of your choice. | $0 |
|  | Home delivered meals  The plan covers up to two prepared meals per day brought to your home if you qualify. | $0 |
|  | Non-medical Transportation  The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify. | $0 |
|  | Preventive Nursing Services  The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may get other nursing services during the nurse visit to your home. These services are not provided on a continuous basis. | $0 |
|  | Private Duty Nursing (PDN)  The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability.  PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician’s orders and in accordance with your plan of care.  You must meet certain medical criteria to qualify for this service. | $0 |
|  | Respite Care Services  You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care.  Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.  Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. | $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 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.]

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

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

## F1. Hospice care

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

See the Benefits Chart in Section D of this chapter [plans may insert reference, as applicable] 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]. You pay nothing for these drugs.

**For services covered by Michigan Medicaid:**

* The provider will bill <plan name> for your services. <Plan name> will pay for the services covered by Michigan Medicaid. You pay nothing for these services.

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

## F2. Services covered by the Prepaid Inpatient Health Plan (PIHP)

The following services are covered by <plan name> but are available through the Prepaid Inpatient Health Plan (PIHP) and its provider network.

Inpatient behavioral health care

* The plan will pay for behavioral health care services that require a hospital stay.

Outpatient substance use disorder services

* We will pay for treatment services that are provided in the outpatient department of a hospital if you, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or if you require treatment but do not require the level of services provided in the inpatient hospital setting.

Partial hospitalization services

* Partial hospitalization is a structured program of active psychiatric treatment. It is offered as 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.

Please see the separate PIHP Member Handbook for more information and work with your Care Coordinator to get services provided through the PIHP.

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

[The services listed in the remaining bullets are excluded from Medicare’s and Michigan Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Michigan Medicaid or under a State’s demonstration, or have become covered due to a Medicare or Michigan 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 Michigan 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 [plans may insert reference, as applicable] for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
* Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.
* A private room in a hospital or nursing facility, except when it is medically necessary.
* Private duty nurses except for those that qualify for this waiver service.
* 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.
* Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
* Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* 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 this if supplemental:] Regular hearing exams.
* [Plans should delete this if supplemental:] Radial keratotomy and LASIK surgery. However, the plan will pay for glasses after cataract surgery.
* Reversal of sterilization procedures and non-prescription contraceptive supplies.
* Acupuncture.
* Naturopath services (the use of natural or alternative treatments).
* Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.