Chapter 4: Benefits Chart

[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.]

Table of Contents

[A. Understanding [insert if the plan has cost sharing: your out-of-pocket costs for] your covered services 2](#_Toc348122227)

[B. Our plan does not allow providers to charge you for services. 2](#_Toc348122228)

[C. About the Benefits Chart 3](#_Toc348122229)

[D. The Benefits Chart 5](#_Toc348122230)

[E. Using our plan’s visitor or traveler benefits 42](#_Toc348122231)

[F. Benefits *not* covered by the plan 42](#_Toc348122232)

# Understanding [insert if the plan has cost sharing: your out-of-pocket costs for]your covered services

This chapter tells you what services <plan name> covers. [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 co-pay. This is a fixed amount (for example, $5) you pay each time you receive that service. You pay the co-pay 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 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 [plans may insert: care coordinator and/or Member Services as <member services number>. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

# Our plan does not allow providers to charge you for services

We do not allow <plan name> providers to bill you for 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. If you do, see Chapter 7** [plans may insert reference, as applicable]**.**

# About the Benefits Chart

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

This 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, General Services offered to all enrollees, and Home and Community-based Services offered to enrollees who qualify through a home and community-based services waiver program. [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 service listed in the Benefits Chart, as long as you meet the coverage requirements described below.**]

* Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need services to prevent, diagnose, or treat your 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 or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.
* [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.]
* [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 other network providers. This is called a referral. Chapter 3 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.]
* [Insert if applicable: Some of the services listed in the Benefits 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 approval first 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 approval first for the following services that are not listed in the Benefits Chart: [insert list].]

[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 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.]

# The Benefits Chart

| General services that our plan covers | | What you must pay |
| --- | --- | --- |
|  | Abdominal aortic aneurysm screening  The plan will cover one ultrasound screening for people at risk. You must get a referral for it at your “Welcome to Medicare” preventive visit.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Alcohol misuse screening and counseling  The plan covers 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, the plan covers 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 |
|  | 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 cover 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 |
|  | Bone mass measurement  The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will cover 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  [List co-pays for additional benefits.] |
|  | Breast cancer screening (mammograms)  The plan will cover 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  [List co-pays for additional benefits.] |
|  | Cardiac (heart) rehabilitation services  The plan covers cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s [insert as appropriate: referral **or** order]. The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
|  | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan covers 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  [List co-pays for additional benefits.] |
|  | Cardiovascular (heart) disease testing  The plan covers 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. Additional testing may be covered if deemed medically necessary by your primary care provider.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Cervical and vaginal cancer screening  The plan covers the following services:  For all women: Pap tests and pelvic exams once every 12 months  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Chiropractic services  The plan covers adjustments of the spine to correct alignment.  [List any plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | [List co-pays.]  [List co-pays for supplemental benefits.] |
|  | Colorectal cancer screening  The plan covers the following services:  Flexible sigmoidoscopy (or screening barium enema) every 48 months  Fecal occult blood test, every 12 months  Screening colonoscopy  For people at high risk of colorectal cancer, the plan will cover one screening colonoscopy (or screening barium enema) every 24 months.  For people not at high risk of colorectal cancer, the plan will cover one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).  Additional screenings may be covered if deemed medically necessary by your primary care provider.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | 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 cover 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 cover two counseling quit attempts  within a 12 month period. Each counseling attempt includes up to four face-to-face visits.  If you use tobacco and are pregnant:  The plan will cover three counseling quit attempts within a 12 month period. This service is free for you. Each counseling attempt includes up to four face-to-face visits.  [List any additional benefits offered.] | $0  [List co-pays for supplemental benefits.] |
|  | **Dental services**  The plan covers the following dental services:   * Limited and comprehensive exams * Restorations * Dentures * Extractions * Sedation * Dental emergencies   Dental services necessary for the health of a pregnant woman prior to delivery of her baby  [List any plan-covered supplemental benefits offered, such as routine dental care, dental X-rays, and cleanings.] | [List co-pays.] |
|  | Depression screening  The plan will cover 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  [List co-pays for additional benefits.] |
|  | Diabetes screening  The plan will cover 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  [List co-pays for additional benefits.] |
|  | Diabetic self-management training, services, and supplies  The plan will cover 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 cover 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 cover fitting the therapeutic custom-molded shoes or depth shoes.  The plan will cover training to help you manage your diabetes, in some cases.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | 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:  placing the person’s health in serious risk; ***or***  serious harm to bodily functions; ***or***  serious dysfunction of any bodily organ or part; ***or***  in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:  There is not enough time to safely transfer the member to another hospital before delivery.  The transfer may pose a threat to the health or safety of the member or unborn child.  [Also identify whether this coverage is within the U.S. or world-wide.] | $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 cover 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  Folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy  The plan will also cover 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 | [List co-pays.] |
|  | [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.] | [List co-pays.] |
|  | [Plans that cover hearing services as a Medicaid benefit should modify the following description if necessary. Add the apple icon if listing only preventive services.]  Hearing services  The plan covers hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  The plan also covers the following:  Basic and advanced hearing tests  Hearing aid counseling  Fitting/evaluation for a hearing aid  Hearing aids once every three years  Hearing aid batteries and accessories  Hearing aid repair and replacement of parts  [List any additional benefits offered.] | [List co-pays.]  [List co-pays for additional benefits.] |
|  | 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  [List co-pays for additional benefits.] |
|  | Home health agency care  [Plans should modify this section to reflect 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 cover the following services, and maybe other services not listed here:  Physical therapy, occupational therapy, and speech therapy  Medical and social services  Medical equipment and supplies | [List co-pays.] |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Hospice care  You can get care from any hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will cover the following:  Drugs to treat symptoms and pain  Short-term respite care  Home care, including home health aide services  Occupational, physical and speech-language therapy services to control symptoms  Counseling services  ***For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:***  The hospice provider will bill Medicare for your services. Medicare will cover 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 illness*** (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 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 illness. You pay [insert as appropriate: the plan’s cost sharing amount ***or*** nothing] for these services. | $0  When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. <Plan name> does not pay for your services.  [Include information about cost sharing for hospice consultation services if applicable.] |
|  | Hospice care  **(continued)**  ***For drugs that may be covered by <plan name>’s Medicare Part D benefit:***   * Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5 [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 illness. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
|  | Immunizations  The plan will cover 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 cover 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  [List co-pays for additional benefits.] |
|  | Inpatient hospital care  [List any restrictions that apply.]  The plan will cover the following services, and maybe other services not listed here:  Semi-private room (or a private room if it is medically necessary)  Meals, including special diets  Regular nursing services  Costs of special care units, such as intensive care or coronary care units  Drugs and medications  Lab tests  X-rays and other radiology services  Needed surgical and medical supplies  Appliances, such as wheelchairs  Operating and recovery room services  Physical, occupational, and speech therapy  Inpatient substance abuse services  Blood, including storage, blood components and administration thereof  Physician services | $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)  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 at a distant location outside the service area. If <plan name> provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.] |  |
|  | Inpatient mental health care  The plan will cover medically necessary psychiatric inpatient care at approved institutions. | $0 |
|  | [Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate.]  Inpatient services covered during a non-covered inpatient stay  If your inpatient stay is not reasonable and needed, the plan will not cover it.  However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:  Doctor services  Diagnostic tests, like lab tests  X-ray, radium, and isotope therapy, including technician materials and services  Surgical dressings  Splints, casts, and other devices used for fractures and dislocations  Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:  replace all or part of an internal body organ (including contiguous tissue), or  replace all or part of the function of an inoperative or malfunctioning internal body organ.  Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition  Physical therapy, speech therapy, and occupational therapy | $0 |
|  | Kidney disease services and supplies  The plan will cover 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” above.** | $0 |
|  | [Plans that cover durable medical equipment as a Medicaid benefit should modify the following description if necessary.]  Medical equipment and related supplies  The following general types of services and items are covered:  Nondurable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy  Durable medical equipment, such as wheelchairs, crutches, walkers, hospital beds, IV infusion pumps and supplies, and humidifiers (for a definition of “Durable medical equipment,” see Chapter 12 [plans may insert reference, as applicable] of this handbook)  Prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports, foot inserts  Respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment  Repair of durable medical equipment, prosthetic devices and orthotic devices  Rental of medical equipment under circumstances where patient’s needs are temporary  To be eligible for reimbursement some services may be subject to prior approval and/or medical criteria.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.] | [List co-pays.] |
|  | Medical equipment and related supplies  (continued)  [Plans that limit the DME brands and manufacturers that you will cover, insert: With this Member Handbook, we sent you <plan name>’s list of durable medical equipment. The list tells you the brands and makers of durable medical equipment that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  Generally, <plan name> covers any durable medical equipment covered by Medicare and Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to <plan name> and are using a brand of durable medical equipment 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 decision about paying for your equipment, 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].)] |  |
|  | 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 cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover 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  [List co-pays for additional benefits.] |
|  | Medicare Part B prescription drugs  These drugs are covered under Part B of Medicare. <Plan name> will cover the following drugs:  Drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services  Drugs you take using 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 needed), topical anesthetics, and erythropoisis-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 |
|  | **Non-emergency transportation**  The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. Types of non-emergency transportation include:  Medicar  Service car  Taxicab  [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.] | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Nursing facility care  The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The nursing facilities provide the following services:  All staff, routine equipment and supplies including oxygen (if less than one tank has been furnished to the resident for the month in question)  Room and board, supervision and oversight, and all laundry services  Food substitutes and nutritional supplements  Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under Department of Public Health regulations  Certain over-the-counter drugs or items ordered by a physician  Additional required services | [List co-pays.] |
|  | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, the plan will cover 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  [List co-pays for additional benefits.] |
|  | Outpatient diagnostic tests and therapeutic services  The plan will cover the following services, and maybe other services not listed here:  X-rays  Radiation (radium and isotope) therapy, including technician materials and supplies  Lab tests  Blood, blood components and administration thereof  Other outpatient diagnostic tests  [Plans can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  The plan pays for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will cover 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  Some screenings and preventive services  Some drugs that you can’t give yourself  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will cover 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,  Community Mental Health Centers (CMHCs),  Hospitals,  Encounter rate clinics such as Federally Qualified Health Centers (FQHCs),  DASA licensed substance abuse providers, ***or***  any other Medicare-qualified mental health care professional as allowed under applicable state laws.  The plan will cover the following types of outpatient mental health services:  Clinic services provided under the direction of a physician  Rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as mental health assessment, treatment planning, crisis intervention, therapy, and case management  Day treatment services  Outpatient hospital services, such as Clinic Option Type A and Type B services  Substance abuse treatment  The specific services each provider type listed above can deliver and any utilization controls on such services shall be determined by the plan consistent with federal and state laws and all applicable policies and/or agreements. | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan will cover 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  The plan covers the following services:  Outpatient services (group or individual)  Intensive outpatient services (group or individual)  Detoxification services  Residential services  Diagnostic Psychiatric Evaluation | [List co-pays.] |
|  | Outpatient surgery  The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Partial hospitalization services  *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting 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 in a hospital outpatient setting.] | $0 |
|  | Physician/provider services, including doctor’s office visits  The plan will cover the following services:  Medically necessary health care or surgery services given in places such as:  physician’s office  certified ambulatory surgical center  hospital outpatient department  Consultation, diagnosis, and treatment by a specialist  Basic hearing and balance exams given by your [insert as applicable: primary care provider **or** specialist], if your doctor orders it to see whether you need treatment  [Insert if the plan has a service area and providers/locations that qualify for telehealth services under the Medicare requirements: Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare]  Second opinion [insert if appropriate: by another network provider] before a medical procedure  Non-routine dental care. Covered services are limited to:  surgery of the jaw or related structures,  setting fractures of the jaw or facial bones,  pulling teeth before radiation treatments of neoplastic cancer, ***or***  services that would be covered when provided by a physician.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | Podiatry services  The plan will cover 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  [List co-pays for additional benefits.] |
|  | Prostate cancer screening exams  The plan will cover a digital rectal exam and a prostate specific antigen (PSA) test once every 12 months for:  Men age 50 and older  African American men age 40 and older  Men age 40 and older with a family history of prostate cancer  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Prosthetic devices and related supplies  *Prosthetic devices* replace all or part of a body part or function. The plan will cover 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 cover 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. | $0 |
|  | Pulmonary rehabilitation services  The plan will cover 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  [List co-pays for additional benefits.] |
|  | Sexually transmitted infections (STIs) screening and counseling  The plan will cover 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 cover 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 cover 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  [List co-pays for additional benefits.] |
|  | 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. or world-wide.] | $0 |
|  | [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 covers the following:  Annual routine eye exams  Eye glasses (lenses and frames) limited to one pair in a 24 month period  Custom-made artificial eye  Low vision devices  To be eligible for reimbursement some services may be subject to prior approval and/or medical criteria.  The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration.  For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include:  people with a family history of glaucoma,  people with diabetes, and  African-Americans who are age 50 and older.  [Plans should modify this description if the plan offers more than is covered by Medicare.] The plan covers 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.) The plan also covers corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant.  [Also list any additional benefits offered, such as supplemental vision exams or glasses.] | $0  [List co-pays for additional benefits.] |
|  | “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.  **Important:** 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 that our plan covers | | **What you must pay** |
| --- | --- | --- |
|  | Adult day service  The plan covers structured day activities at a program of direct care and supervision if you qualify. This service:  Provides personal attention  Promotes social, physical and emotional well-being | $0 |
|  | Assisted living  If you qualify, the Supportive Living Facility provides an alternative to Nursing Facility placement. Some of the services include the following:  Assistance with activities of daily living  Nursing services  Personal care  Medication administration  Housekeeping  24 hour response/security staff | $0 |
|  | Habilitation – day  The plan covers day habilitation, which assists with the retention or improvement in self help, socialization and adaptive skills outside the home if you qualify. | $0 |
|  | Home delivered meals  The plan covers prepared meals brought to your home if you qualify. | $0 |
|  | Home health aide  The plan covers services from a home health aide, under the supervision of a registered nurse (RN) or other professional, if you qualify. Services may include the following:  Simple dressing changes  Assistance with medications  Activities to support skilled therapies  Routine care of prosthetic and orthotic devices | $0 |
|  | Home 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:  Ramps  Grab-bars  Doorway widening | $0 |
|  | Homemaker services  The plan covers home care services provided in your home or community if you qualify. These services may include the following:  A worker to help you with laundry  A worker to help you with cleaning  Training to improve your community living skills | $0 |
|  | Nursing services  The plan covers shift and intermittent nursing services by a registered nurse (RN) or licensed practical nurse (LPN) if you qualify. | $0 |
|  | Personal assistant  The plan covers a personal assistant to help you with activities of daily living if you qualify. These include, for example:  Bathing  Feeding  Dressing  Laundry | $0 |
|  | Personal emergency response system  The plan covers an electronic in home device that secures help in an emergency if you qualify. | $0 |
|  | Respite care  The plan covers respite services to provide relief for an unpaid family member or primary caregiver who meet all of your service needs if you qualify. Certain limitations apply. | $0 |
|  | **Specialized durable medical equipment and supplies**  If you qualify, the plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include:  Hoyer lift  Shower benches/chairs  Stair lift  Bed rails | $0 |
|  | **Therapies**  The plan covers occupational, physical, and speech therapy if you qualify. These therapies focus on long term habilitative needs rather than short term acute restorative needs. | $0 |

# Using 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 receiving 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 *not* covered by the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not cover these benefits.

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

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Medicaid will not cover them either. If you think that we should cover 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, or anywhere else in this *Member Handbook*, [mention any other places where exclusions are given, such as addenda] **the following items and services are not covered by our plan:**

[The services listed in the remaining bullets are excluded from Medicare’s and Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits or are required to be covered by Medicaid or under a State’s demonstration, 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 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 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 needed and Medicare pays for it.

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

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: 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 needed.

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 cover 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: Preventive dental care. Refer to the Dental Services topic for more information on dental coverage.

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

[Plans should delete this if supplemental: Radial keratotomy, LASIK surgery, and vision therapy.

Reversal of sterilization procedures and sex change operations.

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.