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.]

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# Understanding 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 exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Human Services.

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 receive 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 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 <member services number>.

# 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
* Home and Community-Based Waiver Services
* Offered only to enrollees who: 1) require nursing facility level of care but are not residing in a nursing facility, and 2) have a need for covered waiver services

[Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]

**We will pay for the services listed in the Benefits Chart only when the following rules are met. 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 exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Human Services.

* 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. 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.
* 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 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.
* 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].]

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 one method of indication throughout the document; do not use multiple methods.)
* Plans may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Benefits Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* Plans must describe any restrictive policies, limitations, or monetary limits that might affect a beneficiary’s access to services within the chart.
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plans should include all non-waiver LTSS in the chart in alphabetical order.
* All HCBS waiver services should be appended to the end of the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed.]

# The Benefits Chart

| General Services that our plan pays for | | What you must pay |
| --- | --- | --- |
|  | Abdominal aortic aneurysm screening  The plan will pay only once for an 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 |
|  | **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 * 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 | $0 |
|  | [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 |
|  | 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 |
|  | 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 |
|  | 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 |
|  | 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 |
|  | 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 |
|  | 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 cancer: one Pap test every 12 months  For women who have had an abnormal Pap test 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 |
|  | 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  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 non-reoccurring expenses for you to transition from a nursing home to another residence where you are responsible for your own living arrangement. You must have a 6 month continuous stay in the nursing home to receive 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 |
|  | 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 * 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 |
|  | 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 |
|  | 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 |
|  | Diabetic self-management training, services, and supplies  The plan will pay for the following services for all people who have diabetes (whether they use insulin or not):  Supplies to monitor your blood glucose, including  the following:  A blood glucose monitor  Blood glucose test strips  Lancet devices and lancets  Glucose-control solutions for checking the accuracy of test strips and monitors  For people with diabetes who have severe diabetic foot disease, the plan will pay for the following:  One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or***  One pair of depth shoes and three pairs of inserts each year (not including the  non-customized removable inserts provided with such shoes)  The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.  The plan will pay for training to help you manage your diabetes, in some cases.  [List any additional benefits offered.] | $0 |
|  | **Durable medical equipment and related supplies**  (For a definition of “Durable medical equipment,” see Chapter 12 [plans may insert reference, as applicable] of this handbook.)  The following items are covered:  Breast Pumps  Canes  Commodes  CPAP Device  Crutches  Enteral Nutrition  Home Uterine Activity Monitor  Hospital Beds  Incontinence Supplies  Insulin Pump and Supplies  IV Infusion Pumps  Lifts, Slings and Seats  Lymphedema Pump  Nebulizers  Negative Pressure Wound Therapy  Orthopedic Footwear  Orthotics  Osteogenesis Stimulator  Ostomy Supplies  Oxygen Equipment  Parenteral Nutrition  Peak Flow Meter  Pressure Gradient Products  Pressure Reducing Support Surfaces  Prosthetics  Pulse Oximeter  Speech Generating Devices  Surgical Dressings  Tracheostomy Care Supplies  Transcutaneous Electrical Nerve Stimulator  Ventilators  Walkers  Wearable Cardioverter-Defibrillators  Wheelchairs  Some durable medical equipment 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** the ICO **or** 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 durable medical equipment 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: 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 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. 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]*.*)] | $0 |
|  | Emergency care  *Emergency care* means services that are:  given by a provider trained to give emergency services, ***and***  needed to treat a medical emergency.  A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:  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.  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 this coverage is within the U.S. or world-wide.] | $0 |
|  | [Plans should modify this as necessary.]  Family planning services  The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office.  The plan will pay for the following services:  Family planning exam and medical treatment  Family planning lab and diagnostic tests  Family planning methods (birth control pills, patch, ring, IUD, injections, implants)  Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)  Counseling and diagnosis of infertility, and related services  Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions  Treatment for sexually transmitted infections (STIs)  Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)  Genetic counseling  The plan will also pay for some other family planning services. However, you must see a provider in the plan’s network for the following services:  Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)  Treatment for AIDS and other HIV-related conditions  Genetic testing | $0 |
|  | **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.  [List any additional benefits offered, such as routine hearing exams, hearing aids, and evaluations for fitting hearing aids.] | $0 |
|  | HIV screening  The plan pays for one HIV screening exam every 12 months for people who:  ask for an HIV screening test, ***or***  are at increased risk for HIV infection.  For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.  [List any additional benefits offered.] | $0 |
|  | Home health agency care  [Plans should modify this section to reflect 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:  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 |
|  | Immunizations  The plan will pay for the following services:  Pneumonia vaccine  Flu shots, once a year, in the fall or winter  Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B  Other vaccines if you are at risk and they meet Medicare Part B or 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 hospital care  [List any restrictions that apply.]  The plan will pay for the following services, and maybe other services not listed here:  Semi-private room (or a private room if it is medically necessary)  Meals, including special diets  Regular nursing services  Costs of special care units, such as intensive care or coronary care units  Drugs and medications  Lab tests  X-rays and other radiology services  Needed surgical and medical supplies  Appliances, such as wheelchairs  Operating and recovery room services  Physical, occupational, and speech therapy  Inpatient substance use disorder services  In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or 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.]  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 | $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 behavioral health care  The plan will refer you to the Pre-paid 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” below.** | $0 |
|  | 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 receive 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 |
|  | Medicare Part B prescription drugs  These drugs are covered under Part B of Medicare. <Plan name> will pay for the following drugs:  Drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services  Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan  Clotting factors you give yourself by injection if you have hemophilia  Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant  Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself  Antigens  Certain oral anti-cancer drugs and anti-nausea drugs  Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)  IV immune globulin for the home treatment of primary immune deficiency diseases   * **Chapter 5** [plans may insert reference, as applicable] **explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. * **Chapter 6** [plans may insert reference, as applicable] **explains what you pay for your outpatient prescription drugs through our plan.** | $0 |
|  | **Non-emergency medical 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:   * 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 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 receive 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. |
|  | 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 |
|  | 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 needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will pay for the following services, and maybe other services not listed here:  Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery  Labs and diagnostic tests billed by the hospital  Behavioral 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 |
|  | [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 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 Pre-paid 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 Pre-paid 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 in a hospital outpatient setting.] | $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  [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 or care delivery models offered.] | $0 |
|  | Podiatry services  The plan will pay for the following services:  Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)  Routine foot care for members with conditions affecting the legs, such as diabetes  [List any additional benefits offered.] | $0 |
|  | 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 receive 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 |
|  | 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 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 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  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  A hospital stay is not required to receive Skilled Nursing Facility 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 | $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. 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  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. This includes 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, 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 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.) The plan will also pay for 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 |
|  | “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 Waiver Services 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 receive 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 receive 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. |  |

# 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.]

# Covered benefits provided through the Prepaid Inpatient Health Plan (PIHP)

The following services are covered by <plan name> but are available through the Pre-paid 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 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.

* 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 the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not pay for 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 pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Michigan Medicaid will not pay for them either. 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, 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 Michigan Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits or are required to be covered by Michigan 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 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 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 or nursing facility, except when it is medically needed.

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 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 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, hearing aids, or exams to fit hearing aids.

[Plans should delete this if supplemental:] Radial keratotomy, LASIK surgery, and vision therapy. However, the plan will pay for glasses after cataract surgery.

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

Acupuncture.

* Naturopath services (the use of natural or alternative treatments).
* Hospice services: If you choose to enroll in a hospice program, you will be disenrolled from <plan name> and receive all of your medical care and services through Original Medicare and Original (fee-for-service) Michigan Medicaid.

Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.