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 43](#_Toc348122231)

[F. Benefits *not* covered by the plan 43](#_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> pays for. [Insert if the plan has cost sharing: It also tells how much you pay for each service.] You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 [plans may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.]

[Plans with cost sharing, insert: For some services, you will be charged an out-of-pocket cost called a 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 manager 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. [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 the services to prevent, diagnose, or treat a medical condition.
* [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 [insert as appropriate: physician or 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].]

[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.
* 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.

# The Benefits Chart

| 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  [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 will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care [insert as appropriate: physician **or** provider] or practitioner in a primary care setting.  [List any additional benefits offered.] | $0 |
| Ambulance services  Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.  Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan.  In cases that are *not* emergencies, the plan *may* pay for an ambulance. See the transportation section for information on non-emergency transportation. | $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  [List co-pays for additional benefits.] |
| 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  [List co-pays for additional benefits.] |
| 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 [insert as appropriate: physician **or** provider] to help lower your risk for heart disease. During this visit, your doctor may:   * discuss aspirin use, * check your blood pressure, or * give you tips to make sure you are eating well.   [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
| 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  [List co-pays for additional benefits.] |
| 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  [List co-pays for additional benefits.] |
| Chiropractic services  The plan will pay for the following services:   * Adjustments of the spine to correct alignment   [List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | $0  [List co-pays for supplemental benefits.] |
| Clinic services  The plan will pay for clinic services that are preventive, diagnostic, therapeutic, rehabilitative, or palliative. | $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  [List co-pays for additional benefits.] |
| Community mental health rehabilitation services  The plan will pay for medically necessary community mental health rehabilitation services. Authorization may be required. Services include:   * **Psychosocial rehabilitation** – Services provided to groups of adults in a non-residential setting. Services are generally provided using a clubhouse model that gives you a supportive environment where you can:   + get an assessment of your mental illness,   + learn about your mental illness and medicines that can help,   + learn and use independent living skills, and   + enhance your social and interpersonal skills. * **Day treatment/partial hospitalization** – Short term services to stabilize your psychiatric condition. Services are time-limited interventions that are more intensive than outpatient services. * **Mental health skill-building services** – Services to help you learn functional skills and appropriate behavior that you may need as related to your significant mental illness so you can live independently in your community. Services are provided in the most appropriate and least restrictive environment. * **Intensive community treatment** – A variety of services that help you function in your community if you have serious emotional illness and need intensive levels of support. * **Crisis intervention** – Immediate mental health care to assist you if you are having a psychiatric emergency. Services are available 24 hours a day, seven days a week. * **Crisis stabilization** – Direct mental health services that are available if you are not in the hospital and are having a psychiatric emergency that could lead to you being unable to live in your current community. | $0 |
| Community mental health rehabilitation services  (continued)  You may also receive Targeted Case Management (TCM) services directly from the Virginia Department of Medical Assistance Services. TCM offers assistance to individuals with serious mental illness in accessing needed medical, psychiatric, social, educational, vocational and other supports essential to meeting basic needs. You can contact your local community services board for more information about TCM. |  |
| 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.   If you are pregnant, you can get additional support to help you stop smoking. See the Pregnancy Services section for more information.  [List any additional benefits offered.] | $0  [List co-pays for supplemental benefits.] |
| Court ordered services  The plan will pay for all medically necessary court ordered services. | $0 |
| Dental services  <Plan name> will pay for dental services that are provided by a medical doctor when you’ve been in an accident.  [List any plan-covered supplemental benefits offered, such as routine dental care, dental X-rays, and cleanings.] | $0  [List co-pays for additional benefits.] |
| Depression screening  The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
| 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  [List co-pays for additional benefits.] |
| 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  [List co-pays for additional benefits.] |
| [Plans that cover durable medical equipment as a Medicaid benefit should modify the following description if necessary.]  Durable medical equipment (DME) and related supplies  Durable medical equipment (DME) and related supplies are medically necessary supplies and equipment ordered by your doctor for use at home.  The following items are covered:   * Crutches * Hospital beds * IV infusion pumps * Nebulizers * Oxygen and Respiratory equipment and supplies * Positioning devices * Prone standers * Walkers * Wheelchairs   Other items *may* be covered.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary 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.]  [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>. | $0 |
| **Durable medical equipment (DME) and related supplies**  **(continued)**  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].)] |  |
| Elderly or Disabled with Consumer Direction (EDCD) waiver services  This is a home and community-based waiver whose purpose is to provide care in the community rather than in a nursing facility. EDCD waiver services provided by the plan include:   * **Adult day health care** – Health maintenance and rehabilitation coordination services that you get in a group setting during the day. These services are meant to help you stay well enough so that you do not need to go to a nursing facility. * **Agency and/or consumer-directed personal care services** – Long-term maintenance or support services that you need in order to live at home instead of in a nursing facility. * **Agency and/or consumer-directed respite care services** – Short-term personal care services provided to you when your unpaid caregiver who normally provides your care is absent or needs a break. * **Personal emergency response systems** – An electronic device and monitoring service that you use to get help in an emergency. This benefit is available to certain people who are at high risk of going to a nursing facility or other institution. * **Medication monitoring services** – An electronic device that reminds you to take your medications at the correct dosages and times. This benefit is for people who are at high risk of going to a nursing facility or other institution. * **Transition coordination** – Help planning your move from a nursing facility to your home. * **Transition services** – Help with expenses when you are moving from a nursing facility or other institution to a private residence where you are responsible for your own living expenses. Nursing facility or other institution includes a licensed or certified provider-operated living arrangement. | $0 |
| Elderly or Disabled with Consumer Direction (EDCD) waiver services  (continued)  To get EDCD services, the State has to make sure you meet certain criteria. If you need EDCD waiver services, you can contact <plan name> at <phone number> to ask about the process for applying for these services. You can also call the State’s Long Term Care Division at 804-225-4222 for additional information. |  |
| 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 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 |
| [If this benefit is not applicable, plans should delete this row.]  Health and wellness education programs  [These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management. Describe the nature of the programs here.] | $0 |
| Hearing services  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  [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 plan-covered supplemental benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them. These services 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 | $0 |
| **Home health aide services**  The plan covers services from a licensed nurse or a home health aide for members who qualify. Services may include the following:   * Rehabilitation therapies, including physical therapy, occupational therapy, and speech-language therapy * B-12 shots * Insulin injections * Central line and portacath flushes * Blood draws for people who are medically unstable or morbidly obese * Indwelling catheter changes | $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 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  [List co-pays for additional benefits.] |
| 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 abuse 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. See the Transplants section for more information. * Blood, including storage and administration   The plan will pay for whole blood, packed red cells, and 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 mental health care   * The plan will pay for mental health care services that require a hospital stay. * The plan will pay for mental health care services required by a Temporary Detention Order (TDO). A court can order a TDO when a person presents with a substantial risk of harm to self or others. The local Community Services Board then does a psychiatric evaluation to determine whether an involuntarily hospitalization is necessary. | $0 |
| Inpatient services covered during a non-covered inpatient stay  If your inpatient stay is not medically necessary, the plan will not pay for it.  However, in some cases the plan will pay for services you get while you are in the hospital or a nursing facility. The plan will pay for the following services, and maybe other services not listed here:   * Doctor services * Diagnostic tests, like lab tests * X-ray, radium, and isotope therapy, including technician materials and services * Surgical dressings * Splints, casts, and other devices used for fractures and dislocations * Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:   replace all or part of an internal body organ (including contiguous tissue), or  replace all or part of the function of an inoperative or malfunctioning internal body organ.   * Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition * Physical therapy, speech therapy, and occupational therapy | $0 |
| Kidney disease services and supplies  The plan will pay for the following services:   * Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. * Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable] * Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care * Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments * Home dialysis equipment and supplies * Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply   **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” below.** | $0 |
| **Long-Term Services and Supports (LTSS)**  The plan will cover long-term services and supports (LTSS). LTSS help elderly people or people with disabilities with their daily needs. Before you can get LTSS, <plan name> will make sure you qualify for the services. LTSS include help with:   * Bathing * Dressing * Using the toilet * Transferring (for example, moving between the bed, chair, and/or wheelchair) * Laundry * Meal preparation * Housekeeping * Transportation   LTSS also include:   * Nursing Facility Care (see the Nursing facility care section for more information) * Elderly or Disabled with Consumer Direction (EDCD) waiver services (see the EDCD waiver services section for more information) | For Long-Term Services and Supports you may have a patient pay. When your income exceeds an allowable amount, you must contribute toward the cost of your long term care services. This contribution, known as the patient pay amount, is required if you live in a nursing facility or receive EDCD Waiver services. However, you might not end up having to pay each month. |
| 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  [List co-pays for additional benefits.] |
| 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 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 |
| Nursing facility care and skilled 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 * Blood, including storage and administration   The plan will pay for whole blood, packed red cells, and all other parts of blood beginning with the first pint used   * Medical and surgical supplies given by nursing facilities * Lab tests given by nursing facilities * X-rays and other radiology services given by nursing facilities * Appliances, such as wheelchairs, usually given by nursing facilities * Physician/provider services   You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:   * A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) * A nursing facility where your spouse lives at the time you leave the hospital. * The nursing home where you were living when you enrolled in <plan name>. | For Long Term Services and Supports you may have a patient pay. When your income exceeds an allowable amount, you must contribute toward the cost of your long term care services. This contribution, known as the patient pay amount, is required if you live in a nursing facility or receive EDCD Waiver services. 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. |
| Nurse midwives  The plan will cover services provided by nurse midwives as allowed under State licensure requirements and Federal law. | $0 |
| Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care [insert as appropriate: physician **or** provider] to find out more.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
| 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, 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 * 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 Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will pay for mental health services provided by:   * a state-licensed psychiatrist or doctor, * a clinical psychologist, * a clinical social worker, * a clinical nurse specialist, * a nurse practitioner, * a physician assistant, ***or*** * any other Medicare-qualified mental health care professional as allowed under applicable state laws.   The plan will pay for the following medically necessary services, and maybe other services not listed here. Services may require authorization. The plan covers the following services:   * Psychiatric diagnostic exams * Individual medical psychotherapy * Group medical psychotherapy * Family medical psychotherapy * Electroconvulsive therapy * Psychological / Neuropsychological testing * Medication management (these visits are not counted as part of your maximum yearly visits)   [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.]  Outpatient rehabilitation services  The plan will pay for physical therapy, occupational therapy, and speech therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
| Outpatient surgery  The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
| [Plans should modify this section to reflect 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 pay for the following services:   * Medically necessary health care or surgery services given in places such as:   physician’s office  certified ambulatory surgical center  hospital outpatient department   * Consultation, diagnosis, and treatment by a specialist * Basic hearing and balance exams given by your [insert as applicable: primary care [insert as appropriate: physician **or** provider] **or** specialist], if your doctor orders it to see whether you need treatment * Some telehealth services (also called telemedicine), which is when your provider uses interactive/video connections to share information with other providers to help diagnose, treat, or monitor your condition. Providers can use telehealth only in approved areas and only if you agree. * 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 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  [List co-pays for additional benefits.] |
| Pregnancy services  The plan will pay for the following pregnancy-related services: pregnancy education classes, nutritional assessment and counseling, homemaker services, blood glucose meters when medically necessary, and follow-up visits if you leave the hospital less than 48 hours after having your baby.  The plan also pays for coordination and case management services if you have a high-risk pregnancy. Covered services include:   * An assessment to determine your psychosocial, nutritional, and medical needs * A plan to help you get what you need for your pregnancy * Help with connecting you to providers and making sure all your providers are working together * Counseling to stop smoking or tobacco use | $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  [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 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) * Eye prostheses   The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.  The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section [plans may insert reference, as applicable] for details.  [Plans that pay for prosthetic dental devices, delete the following sentence:] The plan will not pay for prosthetic dental devices. | $0 |
| Pulmonary rehabilitation services  The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have [insert as appropriate: a referral **or** an order] for pulmonary rehabilitation from the doctor or provider treating the COPD.  [List any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
| Sexually transmitted infections (STIs) screening and counseling  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care [insert as appropriate: physician **or** provider] must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.  The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care [insert as appropriate: physician **or** provider]. The sessions must be in a primary care setting, such as a doctor’s office.  [Also list any additional benefits offered.] | $0  [List co-pays for additional benefits.] |
| **Substance abuse treatment**  The plan will pay for the following substance abuse treatment services when medically necessary (services may require authorization):   * **Outpatient substance abuse treatment services** –Includes assessment, evaluation, and medication management. Also includes individual, family, and group counseling. * **Substance abuse crisis intervention** –Provides immediate substance abuse care to assist individuals who are experiencing acute dysfunction that needs immediate clinical attention. Services are available 24 hours a day, seven days a week. This service is meant to prevent your condition from getting worse, prevent injury to you or others, and provide treatment in the least restrictive setting. * **Substance abuse residential treatment for pregnant women** –Comprehensive and intensive intervention services in residential facilities, other than inpatient facilities, if you are pregnant or recently had a baby and have serious substance abuse problems. These services are meant to improve your pregnancy outcome, treat your substance abuse disorder, strengthen your relationship with the baby and any other children you have, and help you achieve and maintain a sober and drug-free lifestyle. * **Day treatment for pregnant women –** Substance abuse treatment services provided in a central location during the day for women who are pregnant or recently had a baby. Services include comprehensive and intensive intervention services. These services are meant to improve your pregnancy outcome, treat your substance abuse disorder, strengthen your relationship with the baby and any other children you have, and help you achieve and maintain a sober and drug-free lifestyle. | $0 |
| **Substance abuse treatment**  (continued)   * **Substance abuse day treatment** – Treatment for your substance abuse problem if you do not need to go to a hospital or residential program but need more than outpatient services. These services allow you to get several day-time treatments per week in a non-residential setting. Your treatment can include a combination of diagnostic, medical, psychiatric, and psychosocial services, as well as monitoring and group therapy sessions. * **Opioid treatment –** Treatment for addiction to opioids like Oxycodone and Hydrocodone. Treatment combines psychological and psycho-educational treatment with the administering or dispensing of Opioid agonist treatment medication. |  |
| Temporary Detention Orders (TDOs) and Emergency Custody Orders (ECOs)  A temporary detention order, also called a TDO, is a court order that requires a person to be held in a psychiatric facility for psychiatric evaluation.  An emergency custody order, also called an ECO, is issued if an individual needs to be held involuntarily while awaiting a TDO evaluation or while waiting for a hospital bed after the TDO evaluation.  The plan will cover services as a result of a TDO or an ECO to assess the need for psychiatric hospitalization and treatment. If a judge determines that you can be transferred without medically harmful consequences, the plan may transfer you to another facility for care and treatment. | $0 |
| Transplants  In some cases, the plan will pay for 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.] | $0 |
| Transportation  The plan pays for any medically necessary travel. Non-emergency travel is considered medically necessary when you need help getting to your appointments. The plan covers the following kinds of transportation:   * All emergency transportation * Non-emergency air travel * Non-emergency ground ambulance * Stretcher vans * Wheelchair vans * Public bus * Volunteer / registered drivers * Taxi cabs | $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 Medicaid or plan-covered supplemental benefits as appropriate.]  Vision care  The plan will pay for one routine eye exam and one vision test every 24 months.  The plan will also 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  [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 |
| Wellness visit  The plan covers wellness checkups to make or update a prevention plan. | $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 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*). 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 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.
* Homemaker services, including basic household assistance, light cleaning or making meals.
* 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 pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* [Plans should delete this if dental services are supplemental benefits: Regular dental care, such as cleanings, fillings or dentures. However, dental care required to treat illness or injury may be covered as inpatient or outpatient care.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* Routine foot care, except for the limited coverage provided according to Medicare guidelines.
* Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
* Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
* [Plans should delete this if meals are offered as a supplemental benefit: Meals delivered to your home.
* [Plans should delete this if supplemental: Regular hearing exams, hearing aids, or exams to fit hearing aids.
* [Plans should delete this if supplemental: Eyeglasses, radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids. However, the plan will pay for glasses after cataract surgery.
* Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
* Medications for erectile dysfunction.
* 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.
* 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 standard Medicare and Medicaid.