

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

[Plans should refer to other parts of the Member Handbook using the appropriate chapter number and section as appropriate. For example, "refer to Chapter 9, Section A." An instruction [insert reference, as applicable] appears with many cross references throughout the Member Handbook. Plans can always include additional references to other sections, chapters, and/or member materials when helpful to the reader.]

[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

Table of Contents

A. Information about services and providers.....	4
B. Rules for getting services our plan covers.....	4
C. Your care coordinator.....	6
C1. What a care coordinator is.....	6
C2. How you can contact your care coordinator.....	6
C3. How you can change your care coordinator.....	6
D. Care from providers.....	6
D1. Care from a primary care provider (PCP).....	6
D2. Care from specialists and other network providers.....	8
D3. When a provider leaves our plan.....	8
D4. Out-of-network providers.....	9



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

E. Long-term services and supports (LTSS).....	10
F. Behavioral health (mental health and substance use disorder) services.....	10
G. <i>[If applicable plans should add: How to get self-directed care]</i>	10
G1. What self-directed care is.....	10
G2. Who can get self-directed care (for example, if it's limited to waiver populations).....	10
G3. How to get help in employing personal care providers (if applicable).....	10
H. Transportation services.....	10
I. Covered services in a medical emergency, when urgently needed, or during a disaster.....	11
I1. Care in a medical emergency.....	11
I2. Urgently needed care.....	12
I3. Care during a disaster.....	13
J. What if you're billed directly for covered services.....	13
J1. What to do if our plan doesn't cover services.....	14
K. Coverage of health care services in a clinical research study.....	14
K1. Definition of a clinical research study.....	14
K2. Payment for services when you're in a clinical research study.....	15
K3. More about clinical research studies.....	15
L. How your health care services are covered in a religious non-medical health care institution.....	15
L1. Definition of a religious non-medical health care institution.....	15
L2. Care from a religious non-medical health care institution.....	16
M. Durable medical equipment (DME).....	16
M1. DME as a member of our plan.....	16
M2. DME ownership if you switch to Original Medicare.....	17
M3. Oxygen equipment benefits as a member of our plan.....	17



M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan.....	18
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A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment *[insert if plan has cost-sharing: and your cost-sharing amount]* as full payment. *[Plans can delete the next sentence if it isn't applicable.]* We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay *[insert as applicable: nothing or only your share of the cost]* for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and <Medicaid program name>. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans can revise the state-specific definition of "medically necessary" as appropriate and ensure that it's updated and used consistently throughout member material models.]*
- *[Plans can omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.]* For medical services, you must have a network **primary care**



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

provider (PCP) providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (go to **Section D1** for more information).

- o In most cases, *[insert as applicable: your network PCP or our plan]* must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
- o *[Insert if applicable: Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you're also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is <definition>.]*
- o You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (go to **Section D1** for more information).
- *[Plans with a POS option can edit the network provider bullets as necessary.]* **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:
 - o We cover emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I**).
 - o If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. *[Plans can specify whether authorization should be obtained before seeking care.]* In this situation, we cover the care *[insert as applicable: as if you got it from a network provider or at no cost to you]*. For information about getting approval to use an out-of-network provider, go to **Section D4**.
 - o We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. *[Insert as applicable: The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost-sharing for the dialysis may be higher.]* If possible, call Member Services at the number at the bottom of the page



before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

[Plans add additional exceptions as appropriate including exceptions as required by the state.]

C. Your care coordinator

[Plans provide applicable information about the care coordinator and care coordination, as well as explanations for the following subsections. Plans should replace the terms "care coordinator" and "care team" with terms they use. If Plans use more than one type of "care coordinator," multiple descriptions can be provided that describe each type, or additional language can be added to the care coordinator definition below.]

C1. What a care coordinator is

[Example text: A care coordinator is a trained person who works for our plan to provide care coordination services for you.]

C2. How you can contact your care coordinator

C3. How you can change your care coordinator

D. Care from providers

D1. Care from a primary care provider (PCP)

[Insert if applicable and adjust language to describe PCP requirements: You must choose a PCP to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you're also choosing the affiliated medical group.]

Definition of a PCP and what a PCP does do for you

[Plans describe the following in the context of their plans:

What a PCP is

If applicable, what a medical group or IPA is

What types of providers may act as a PCP [If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP.]

The role of a PCP in

- *coordinating covered services*
- *making decisions about or getting prior authorization (PA), if applicable*



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

When a clinic can be your PCP (RHC/FQHC)]

Your choice of PCP

[Plans describe how to choose a PCP. Plans that assign members to medical groups or IPAs must include language that explains how the choice of PCP will affect member access to specialists and hospitals. For example: If there's a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the Provider and Pharmacy Directory, or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.]

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

[Plans describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]

[Insert if applicable: Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.]

Services you can get without approval from your PCP

[Insert the following section only if plans require referrals to network providers.]

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccines, *[insert if applicable: as well as hepatitis B vaccines and pneumonia vaccines]* *[insert if applicable: as long as you get them from a network provider]*.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams *[insert if applicable: as long as you get them from a network provider]*.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

[Plans add additional bullets consistently formatted like the rest of this section as appropriate.]

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

[Plans must describe how members access specialists and other network providers, including:

The role (if any) of the PCP in referring members to specialists and other providers.

A description of PA as well as the process for getting PA. Plans should explain that PA means the member gets plan approval before getting a specific service or drug or using an out-of-network provider, and plans include information about who makes the PA decision (e.g., Medical Director, the PCP, or another entity). Refer members to Chapter 4 for information about which services require PA.

If the PCP selection results in being limited to specific specialists or hospitals to which that PCP refers. For example, plans should include information about subnetworks if applicable.]

D3. When a provider leaves our plan

[Plans can edit this section if Medicaid requires them to have a transition benefit when a provider leaves the plan.]



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
 - o If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
 - o If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. *[Plans should indicate if prior authorization is needed.]*
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** *[plans can insert reference, as applicable]* for more information.)

D4. Out-of-network providers

[Plans tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services aren't available in network). Include Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.] [Note: Members are entitled to get services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

dialysis services for ESRD members who have traveled outside the plan's service area or when the provider is temporarily unavailable or not accessible and aren't able to access contracted ESRD providers.]

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or <Medicaid program name>.

- We can't pay a provider who isn't eligible to participate in Medicare and/or <Medicaid program name>.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

[Plans should provide applicable information about getting LTSS.]

F. Behavioral health (mental health and substance use disorder) services

[Plans should provide applicable information about getting behavioral health services.]

G. [If applicable plans should add: How to get self-directed care]

[Plans should provide applicable information about getting self-directed care, including the following subsections.]

G1. What self-directed care is

G2. Who can get self-directed care (for example, if it's limited to waiver populations)

G3. How to get help in employing personal care providers (if applicable)

H. Transportation services

[Plans should provide applicable information about getting transportation services.]

I. Covered services in a medical emergency, when urgently needed, or during a disaster



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

11. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life *[insert as applicable: and, if you're pregnant, loss of an unborn child]*; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- *[Insert as applicable: In the case of a pregnant woman in active labor, when:*
 - o There isn't enough time to safely transfer you to another hospital before delivery.
 - o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories *[insert as applicable: or worldwide]*, from any provider with an appropriate state license even if they're not part of our network.
- *[Plans add if applicable: As soon as possible, tell our plan about your emergency. We follow up on your emergency care. You or someone else [plans can replace "someone else" with "your care coordinator" or other applicable term] should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us.] [Plans must provide the contact phone number and days and hours of operation or explain where to find the information (e.g., on the back of the Member ID Card).]*

Covered services in a medical emergency

[Plans that cover emergency medical care outside the United States or its territories through Medicaid can describe this coverage based on the Medicaid program coverage area. Plans must also include language emphasizing that Medicare doesn't provide coverage for emergency medical care outside the United States and its territories.]



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

[Plans can add to this paragraph as needed to include other information about their post-stabilization care.] Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

12. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it isn't possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.

[Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).]

Urgently needed care outside our plan's service area



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

[Plans that cover urgently needed care outside the United States or its territories through Medicaid can describe this coverage based on the Medicaid program coverage area.]

[Insert if applicable: Our plan doesn't cover urgently needed care or any other [insert if plan covers emergency care outside of the United States and its territories: non-emergency] care that you get outside the United States and its territories.]

[Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit: Our plan covers worldwide [Insert as applicable: emergency and urgently needed care OR emergency OR urgently needed care] services outside the United States and its territories under the following circumstances [insert details.]]

13. Care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster:

<URL>. *[In accordance with 42 CFR 422.100(m), plans must include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost-sharing without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster's start and end dates.]*

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at *[insert as applicable: the in-network cost-sharing rate or no cost to you]*. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

J. What if you're billed directly for covered services

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid-covered benefits.]

*[Insert as applicable: If you paid for your covered services or If you paid more than your plan cost-sharing for covered services] or if you got a bill for [plans with cost-sharing, insert: the full cost of] covered medical services, refer to **Chapter 7** of this *Member Handbook* to find out what to do.*



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

J1. What to do if our plan doesn't cover services

[Plans with an arrangement with the state can add language to reflect that the organization isn't allowed to reimburse members for Medicaid-covered benefits.]

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Member Handbook*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

[If applicable, plans revise this section to describe Medicaid role in providing coverage and payment for clinical research studies.]

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us *[plans that don't use PCPs can delete the rest of this sentence]* or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you'll take part in a clinical trial.

K2. Payment for services when you're in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

[Plans that conduct or cover clinical trials that aren't approved by Medicare insert: If you volunteer for a clinical research study, we pay any costs that Medicare doesn't approve but that our plan approves.] If you're part of a study that Medicare *[plans that conduct or cover clinical trials that aren't approved by Medicare, insert: or our plan]* hasn't approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/coverage/clinical-research-studies). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

L. How your health care services are covered in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

[If applicable, plans revise this section to describe Medicaid's role in providing care in religious non-medical health care institutions.]



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **not voluntary and is required** under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility:
 - o You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - o *[Omit this bullet if not applicable]* You must get approval from us before you're admitted to the facility, or your stay **won't** be covered.

*[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in **Chapter 4** [insert reference, as applicable]) or whether there's unlimited coverage for this benefit.]*

M. Durable medical equipment (DME)

M1. DME as a member of our plan

[Plans can modify this section as directed by the state.]

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you *[insert if the plan sometimes allows transfer of ownership to the member: usually]* **won't** own the rented DME items, no matter how long you rent it.

[If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions and when the member can own specified DME.]

[If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert: In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the phone number at the bottom of the page for more information.]

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you **won't** own the equipment.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents



If you have questions, please call <plan name> at <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free. **For more information**, visit <URL>.

- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

