

## Chapter 4: Benefits chart

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### Introduction

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

*[Plans should refer to other parts of the Member Handbook using the appropriate chapter number and section. 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.]*



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

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## A. Your covered services *[insert if the plan has cost-sharing: and your out-of-pocket costs]*

This chapter tells you about services our plan covers *[insert if the plan has cost-sharing: and how much you pay for each service]*. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. *[Insert if applicable: This chapter also explains limits on some services.]*

*[Plans with cost-sharing, insert: For some services, you're charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.]*

*[Plans with no cost-sharing for any services described in this chapter, insert: Because you get help from <Medicaid program name>, you pay nothing for your covered services as long as you follow our plan's rules. Refer to Chapter 3 of this Member Handbook for details about our plan's rules.]*

If you need help understanding what services are covered, call *[insert: your care coordinator and/or Member Services at <phone number(s)>]*.

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## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7** of this *Member Handbook* or call Member Services.

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## C. About our plan's Benefits Chart

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

The Benefits Chart tells you the services our plan pays for *[plans with cost-sharing insert: and what you pay out of pocket for each service]*. (Drug coverage is in **Chapter 5**.) It lists covered services in alphabetical order and explains them. *[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 pay for the services listed in the Benefits Chart when the following rules are met.**

*[Plans that don't have cost-sharing, insert: You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]*



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- We provide covered Medicare and <Medicaid program name> covered services according to the rules set by Medicare and <Medicaid program name>.
- The services *[Plans can revise as applicable: (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)]* must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. *[Plans can revise and use the state-specific definition of “medically necessary” and ensure that it’s updated and used consistently in **Chapter 12** and throughout member materials.]*
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- *[Insert if applicable: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won’t be covered unless it’s an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.]*
- *[Insert if applicable: You have a primary care provider (PCP) or a care team providing and managing your care. *[Plans that don’t require referrals, omit the rest of this paragraph:]* In most cases, your PCP 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. **Chapter 3** of this *Member Handbook* has more information about getting a referral and when you **don’t** need one.]*
- *[Plans can add information about any continuity of care requirements as directed by the state.]*
- *[Insert if applicable: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA *[insert as appropriate: with an asterisk (\*) or with a footnote or in bold type or in italic type].* *[Insert if applicable: In addition, you must get PA for the following services not listed in the Benefits Chart: *[insert list].***



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- *[Insert if applicable: If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.]*
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* <insert year> handbook. View it online at [www.Medicare.gov](http://www.Medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- If Medicare adds coverage for any new services during <insert year>, either Medicare or our plan will cover those services.
- *[Insert if not covering Medicaid benefits during a deemed continued eligibility period and adjust language to accurately describe benefits: If you lose your <Medicaid program name> within the [Enter plan deeming period. Plans can choose any length of time from one to six months for deemed continued eligibility, as long as the plan applies the criteria consistently across all members and fully informs members of the policy]-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, your <Medicaid program name> coverage may end sooner than your Medicare coverage with us. When your <insert Medicaid name> coverage ends, we won't pay for your <insert Medicaid name> benefits. [Describe impact on Medicare cost-sharing, if any, during the period.]*

We'll assist you to regain your <Medicaid program name> eligibility. If your <Medicaid program name> eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your <Medicaid program name> benefits and your enrollment with us will continue. If you regain <Medicaid program name> eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.]

- *[Insert if covering Medicaid benefits during deemed continued eligibility period and adjust language to accurately describe benefits: If you're within our plan's [Enter plan deeming period. Plans can choose any length of time from one to six months for deeming continued eligibility, as long as the plan applies the criteria consistently across all members and fully informs members of the policy]-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage and <Medicaid program name> plan-covered benefits. During this time, we'll assist you to regain <Medicaid program name> eligibility. If you regain <Medicaid program name> eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.]*

*[Instructions to plans offer MA Uniformity Flexibility benefits:*



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- *Plans must deliver to each clinically targeted enrollee a written summary of those benefits or information in alignment with its different strategy for communicating information regarding MA Uniformity Flexibility benefits for which they're eligible.*
- *If applicable, plans must update the Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered.]*

*[Insert if offering Special Supplemental Benefits for the Chronically Ill (SSBCI): Important Benefit Information for Members with Certain Chronic Conditions.*

- *If you have any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill [insert if applicable: and/or reduced cost-sharing]:*
  - *[List all applicable chronic conditions here.]*
  - *[Include information about the process and/or criteria for determining eligibility for SSBCI.]*
- *For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Benefits Chart below.]*
- *Contact us to find out exactly which benefits you may be eligible for.]*

*[Insert as applicable: Most or All]* preventive services are free. This apple 🍏 shows the preventive services in the Benefits Chart.

*[Insert any additional applicable Medicaid program coverage here such as community supports.]*

*[Instructions on completing the Benefits Chart:*

- *For all preventive care and screening test benefit information, plans that cover a richer benefit don't need to include the given description (unless it's still applicable) and can instead describe the plan benefit.*
- *Optional supplemental benefits aren't permitted in this chart; optional supplemental benefits should be described in **Section E**.*
- *Include the following where appropriate: Talk to your provider and get a referral.*
- *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services with the apple icon.*
- *HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS*



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*benefit, and any differences in cost-sharing for covered services obtained out-of-network under the POS benefit.*

- *Plans should clearly indicate which benefits are subject to PA. (This can be done with asterisks, footnotes, bold type, or italic type. Plans must select only one method of indication, describe it in terms easily understandable by members, make the indication and description prominently visible, and use it consistently throughout the document.)*
- *Plans can insert any additional benefit information that's based on the plan's approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
- *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
- *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member's access to services within the chart.*
- *Plans can 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 doesn't resemble any exclusion, then the plan shouldn't reference the exclusion list.*
- *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
- *Plans with no cost-sharing for any type of service (i.e., no cost-sharing at all) may delete the "what you must pay" column from the table. Plans with any type of cost-sharing for services, including for pharmacy services, must leave the "what you must pay" column in the table.*
- *Plans offering targeted supplemental benefits in Section B-19 of the Plan Benefit Package submission must:*
  - *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the "Uniformity Flexibility" benefits for which they're eligible.*
  - *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost-sharing amount for each specific service and/or the additional supplemental benefits being offered.]*



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## D. Our plan's Benefits Chart

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

*[Plans should modify this section throughout to reflect Medicaid or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid.]*

Covered Service	What you pay
 <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>




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Covered Service	What you pay
<p><b>Acupuncture</b></p> <p>We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> <li>• lasting 12 weeks or longer;</li> <li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li> <li>• not associated with surgery; <b>and</b></li> <li>• not associated with pregnancy.</li> </ul> <p>In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments must be stopped if you don't get better or if you get worse.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	





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Covered Service	What you pay
<p><b>Acupuncture (continued)</b></p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> <li>• a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</li> <li>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.</li> </ul> <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p><a href="#">[List any additional benefits offered.]</a></p>	<p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p>
<p> <b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.</p> <p><a href="#">[List any additional benefits offered.]</a></p>	<p>\$0</p>





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Covered Service	What you pay
<p><b>Ambulance services</b></p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life.</p> <p>Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</p>	\$0
<p> <b>Annual wellness visit</b></p> <p>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.</p> <p><b>Note:</b> Your first annual wellness visit can't take place within 12 months of your <b>Welcome to Medicare</b> visit. However, you don't need to have had a <b>Welcome to Medicare</b> visit to get annual wellness visits after you've had Part B for 12 months.</p> <p><a href="#">[List any additional benefits offered.]</a></p>	\$0
<p> <b>Bone mass measurement</b></p> <p>We 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.</p> <p>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.</p> <p><a href="#">[List any additional benefits offered.]</a></p>	<p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p>





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Covered Service	What you pay
 <p><b>Breast cancer screening (mammograms)</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>one baseline mammogram between the ages of 35 and 39 <i>[plans that only cover ages 65 and over should delete]</i></li> <li>one screening mammogram every 12 months <i>[plans that cover women under 65 should include: for women aged 40 and over]</i></li> <li>clinical breast exams once every 24 months</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p><b>Cardiac (heart) rehabilitation services</b></p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's <i>[insert as appropriate: referral or order]</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p>	<p>\$0</p>
 <p><b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b></p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the <i>[visit or visits]</i>, your doctor may:</p> <ul style="list-style-type: none"> <li>discuss aspirin use,</li> <li>check your blood pressure, <b>and/or</b></li> <li>give you tips to make sure you're eating well.</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>




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Covered Service	What you pay
 <b>Cardiovascular (heart) disease screening tests</b> We pay 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. <a href="#">[List any additional benefits offered.]</a>	\$0 <a href="#">[List copays for additional benefits.]</a>
 <b>Cervical and vaginal cancer screening</b> We pay for the following services: <ul style="list-style-type: none"> <li>for all women: Pap tests and pelvic exams once every 24 months</li> <li>for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li><a href="#">[Plans that cover women under 65 must include: for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months]</a></li> </ul> <a href="#">[List any additional benefits offered.]</a>	\$0 <a href="#">[List copays for additional benefits.]</a>
<b>Chiropractic services</b> We pay for the following services: <ul style="list-style-type: none"> <li>adjustments of the spine to correct alignment</li> </ul> <a href="#">[List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.]</a>	<a href="#">[List copays.]</a> <a href="#">[List copays for supplemental benefits.]</a>
<b>Chronic pain management and treatment services</b> Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	<a href="#">[Insert as applicable: Cost-sharing for this service will vary depending on individual services provided under the course of treatment.]</a> <a href="#">[List copays.]</a>



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>.

Covered Service	What you pay
<div data-bbox="207 283 251 331"></div> <p><b>Colorectal cancer screening</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy.</li> <li>• Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.</li> <li>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography.</li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p><b>\$0</b></p> <p><i>[List copays for additional benefits.]</i></p>




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Covered Service	What you pay
<p><b>Colorectal cancer screening (continued)</b></p> <ul style="list-style-type: none"> <li>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.</li> <li>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.</li> <li>• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p><i>[List copays for additional benefits.]</i></p>




**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>.



Covered Service	What you pay
<p><i>[Modify to accurately describe the Medicaid and/or supplemental benefit offered.]</i></p> <p><b>Dental services</b></p> <p>Certain dental services, including cleanings, fillings, and dentures, are available through the &lt;Medicaid program name&gt; Dental Program.</p> <p>We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.</p> <p><i>[Plans that offer optional supplemental dental benefits at an additional cost insert: Note: Our plan offers additional dental services. Go to the Benefits Chart in <b>Section E</b> for more information.]</i></p>	<p><i>[If plan offers supplemental benefit, the maximum copay amount is \$10.]</i></p>
 <p><b>Depression screening</b></p> <p>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>




**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>.

Covered Service	What you pay
<div data-bbox="207 285 250 327"></div> <p><b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> <li>• high blood pressure (hypertension)</li> <li>• history of abnormal cholesterol and triglyceride levels (dyslipidemia)</li> <li>• obesity</li> <li>• history of high blood sugar (glucose)</li> </ul> <p>Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes.</p> <p>You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p> <p><a href="#">[List any additional benefits offered.]</a></p>	<p>\$0</p> <p><a href="#">[List copays for additional benefits.]</a></p>



**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>.

Covered Service	What you pay
<div data-bbox="207 283 251 331"></div> <p><b>Diabetic self-management training, services, and supplies</b></p> <p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> <li>Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> <li>a blood glucose monitor</li> <li>blood glucose test strips</li> <li>lancet devices and lancets</li> <li>glucose-control solutions for checking the accuracy of test strips and monitors</li> </ul> </li> <li>For people with diabetes who have severe diabetic foot disease, we pay for the following: <ul style="list-style-type: none"> <li>one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li> <li>one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li> </ul> </li> <li>In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p><b>\$0</b></p> <p><i>[List copays for additional benefits.]</i></p>



Covered Service	What you pay
<p><b>Durable medical equipment (DME) and related supplies</b></p> <p>Refer to <b>Chapter 12</b> of this <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>• wheelchairs</li> <li>• crutches</li> <li>• powered mattress systems</li> <li>• diabetic supplies</li> <li>• hospital beds ordered by a provider for use in the home</li> <li>• intravenous (IV) infusion pumps and pole</li> <li>• speech generating devices</li> <li>• oxygen equipment and supplies</li> <li>• nebulizers</li> <li>• walkers</li> <li>• standard curved handle or quad cane and replacement supplies</li> <li>• cervical traction (over the door)</li> <li>• bone stimulator</li> <li>• dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p><b>This benefit is continued on the next page</b></p>	<p><i>[List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable.]</i></p> <p><i>[Include if applicable: Your cost-sharing for Medicare oxygen equipment coverage is [insert copay amount or coinsurance percentage], every [insert required frequency of payment].]</i></p> <p><i>[Plans that use a constant cost-sharing structure for oxygen equipment insert: Your cost-sharing won't change after being enrolled for 36 months.]</i></p>



**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>.

Covered Service	What you pay
<p><b>Durable medical equipment (DME) and related supplies (continued)</b></p> <p><i>[Plans that don't limit the DME brands and manufacturers that they cover, insert: We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you.]</i></p> <p><i>[Plans that limit the DME brands and manufacturers that they cover, insert the following (for more information about this requirement, refer to <b>Chapter 4</b> of the Medicare Managed Care Manual): With this Member Handbook, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You can also find the most recent list of brands, makers, and suppliers on our website at &lt;URL&gt;.</i></p> <p><i>Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We don't cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you're new to our plan and using a brand of DME not on our list, we'll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)</i></p> <p><i>If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to <b>Chapter 9</b> of this Member Handbook.]</i></p>	<p><i>[Plans that wish to vary cost-sharing for oxygen equipment after 36 months insert details including whether original cost-sharing resumes after 5 years and you're still in the plan.] [If cost-sharing is different for members who made 36 months of rental payments prior to joining the plan insert: If prior to enrolling in &lt;plan name&gt; is [insert cost-sharing].]</i></p>



**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>.

Covered Service	What you pay
<p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>• given by a provider trained to give emergency services, <b>and</b></li> <li>• needed to evaluate or treat a medical emergency.</li> </ul> <p>A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. 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:</p> <ul style="list-style-type: none"> <li>• serious risk to your life <i>[Plans that cover women under 65 must include: or to that of your unborn child]; or</i></li> <li>• serious harm to bodily functions; <b>or</b></li> <li>• loss of a limb, or loss of function of a limb.</li> <li>• <i>[Plans that cover women under 65 must include: In the case of a pregnant woman in active labor, when:</i> <ul style="list-style-type: none"> <li>o There isn't enough time to safely transfer you to another hospital before delivery.</li> <li>o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]</li> </ul> </li> </ul> <p><i>[Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]</i></p>	<p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, <i>[plans should insert information as needed to accurately describe emergency care benefits: (e.g., you must move 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 our plan approves your stay.)]</i>.</p>




**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>.

Covered Service	What you pay
<p data-bbox="277 289 1062 359"><i>[If family planning services are covered, plans should modify this as necessary.]</i></p> <p data-bbox="277 380 626 415"><b>Family planning services</b></p> <p data-bbox="277 443 1036 590">The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p data-bbox="277 611 716 646">We pay for the following services:</p> <ul data-bbox="277 659 1084 1465" style="list-style-type: none"> <li>• family planning exam and medical treatment</li> <li>• family planning lab and diagnostic tests</li> <li>• family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>• family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>• counseling and diagnosis of infertility and related services</li> <li>• counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>• counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>• permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• genetic counseling</li> </ul> <p data-bbox="277 1493 1073 1598">We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul data-bbox="277 1619 1073 1822" style="list-style-type: none"> <li>• treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.)</li> <li>• treatment for AIDS and other HIV-related conditions</li> <li>• genetic testing</li> </ul>	<p data-bbox="1166 289 1338 325"><i>[List copays.]</i></p>




**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>.

Covered Service	What you pay
 <b>Health and wellness education programs</b> <i>[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.]</i> <i>[If this benefit isn't applicable, plans should delete this row.]</i>	<i>[List copays.]</i>
<i>[Plans should modify this section to reflect plan-covered benefits as appropriate.]</i> <b>Hearing services</b> We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	<i>[List copays.]</i> <i>[List copays for additional benefits.]</i>
<i>[If this benefit isn't applicable, plans should delete this row.]</i> <b>Help with certain chronic conditions</b> <i>[If the enrollee has been diagnosed by a plan provider with the certain chronic condition(s) identified and meets certain criteria, they may be eligible for other targeted supplemental benefits and/or targeted reduced cost-sharing. The certain chronic conditions must be listed here. The benefits listed here must be approved in the bid. Describe the nature of the benefits here.]</i>	<i>[List copays.]</i>



**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>.



Covered Service	What you pay
 <b>HIV screening</b> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> <li>ask for an HIV screening test, <b>or</b></li> <li>are at increased risk for HIV infection.</li> </ul> <p>If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p><b>Home health agency care</b></p> <p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.)</li> <li>physical therapy, occupational therapy, and speech therapy</li> <li>medical and social services</li> <li>medical equipment and supplies</li> </ul>	<p><i>[List copays.]</i></p>



**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>.


Covered Service	What you pay
<p><b>Home infusion therapy</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"> <li>• the drug or biological substance, such as an antiviral or immune globulin;</li> <li>• equipment, such as a pump; <b>and</b></li> <li>• supplies, such as tubing or a catheter.</li> </ul> <p>Our plan covers home infusion services that include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• professional services, including nursing services, provided in accordance with your care plan;</li> <li>• member training and education not already included in the DME benefit;</li> <li>• remote monitoring; <b>and</b></li> <li>• monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
<p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• drugs to treat symptoms and pain</li> <li>• short-term respite care</li> <li>• home care</li> </ul> <p><b>For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:</b></p> <ul style="list-style-type: none"> <li>• Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay <i>[insert as appropriate: our plan's cost-sharing amount or nothing]</i> for these services.</li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p><i>[List copays.]</i></p> <p><i>[Include information about cost-sharing for hospice consultation services if applicable.]</i></p>



Covered Service	What you pay
<p><b>Hospice care</b></p> <p><b>For drugs that may be covered by our plan's Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of this <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that <b>isn't</b> related to your terminal prognosis.</p> <p><i>[Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit.]</i></p>	<p><i>[List copays.]</i></p> <p><i>[Include information about cost-sharing for hospice consultation services if applicable.]</i></p>
<p> <b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>pneumonia vaccines</li> <li>flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary</li> <li>hepatitis B vaccines if you're at high or intermediate risk of getting hepatitis B</li> <li>COVID-19 vaccines</li> <li>other vaccines if you're at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of this <i>Member Handbook</i> to learn more.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
<p><b>Inpatient hospital care</b></p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p><i>[List any restrictions that apply.]</i></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• semi-private room (or a private room if medically necessary)</li> <li>• meals, including special diets</li> <li>• regular nursing services</li> <li>• costs of special care units, such as intensive care or coronary care units</li> <li>• drugs and medications</li> <li>• lab tests</li> <li>• X-rays and other radiology services</li> <li>• needed surgical and medical supplies</li> <li>• appliances, such as wheelchairs</li> <li>• operating and recovery room services</li> <li>• physical, occupational, and speech therapy</li> <li>• inpatient substance abuse services</li> <li>• in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p>\$0</p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p>



**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>.

Covered Service	What you pay
<p><b>Inpatient hospital care (continued)</b></p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. <i>[Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.]</i></p> <ul style="list-style-type: none"> <li>• blood, including storage and administration</li> <li>• physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at <a href="https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>	
<p><b>Inpatient services in a psychiatric hospital</b></p> <p>We pay for mental health care services that require a hospital stay. <i>[List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.]</i></p> <p><i>[List any additional benefits offered.]</i></p>	\$0



**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>.

Covered Service	What you pay
<p><i>[Plans with no day limitations on a plan's hospital or nursing facility coverage may modify or delete this row as appropriate.]</i></p> <p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</b></p> <p>We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• doctor services</li> <li>• diagnostic tests, like lab tests</li> <li>• X-ray, radium, and isotope therapy, including technician materials and services</li> <li>• surgical dressings</li> <li>• splints, casts, and other devices used for fractures and dislocations</li> <li>• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> <li>o an internal body organ (including contiguous tissue), <b>or</b></li> <li>o the function of an inoperative or malfunctioning internal body organ.</li> </ul> </li> <li>• 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 your condition</li> <li>• physical therapy, speech therapy, and occupational therapy</li> </ul>	\$0





**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>.

Covered Service	What you pay
<p><b>Kidney disease services and supplies</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.</li> <li>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in <b>Chapter 3</b> of this <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible.</li> <li>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care</li> <li>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments</li> <li>• Home dialysis equipment and supplies</li> <li>• 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.</li> </ul> <p>Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.</p>	<p>\$0</p>




**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>.



Covered Service	What you pay
 <p><b>Lung cancer screening with low dose computed tomography (LDCT)</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• are aged 50-77, <b>and</b></li> <li>• have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.</p> <p><i>[Modify section to accurately describe benefits and list any additional benefits offered.]</i></p>	<p>\$0</p>
 <p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when <i>[insert as appropriate: referred or ordered]</i> by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>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 <i>[insert as appropriate: referral or order]</i>. A doctor must prescribe these services and renew the <i>[insert as appropriate: referral or order]</i> each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service		What you pay
	<b>Medicare Diabetes Prevention Program (MDPP)</b>  Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: <ul style="list-style-type: none"><li>• long-term dietary change, <b>and</b></li><li>• increased physical activity, <b>and</b></li><li>• ways to maintain weight loss and a healthy lifestyle.</li></ul>	\$0



**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>.

Covered Service	What you pay
<p><b>Medicare Part B drugs</b></p> <p><i>[Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).]</i></p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> <li>• drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)</li> <li>• other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• the Alzheimer's drug Leqembi<sup>®</sup> (generic lecanemab) which is given intravenously (IV)</li> <li>• clotting factors you give yourself by injection if you have hemophilia</li> <li>• transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them</li> <li>• osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself</li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



**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>.

Covered Service	What you pay
<p><b>Medicare Part B drugs (continued)</b></p> <ul style="list-style-type: none"> <li>• some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision</li> <li>• certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does</li> <li>• oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug</li> <li>• certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B</li> <li>• calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv<sup>®</sup>, and the oral medication Sensipar</li> <li>• certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics</li> <li>• erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions <i>[plans may delete any of the following drugs that they don't cover]</i> (such as Epogen<sup>®</sup>, Procrit<sup>®</sup>, Retacrit<sup>®</sup>, Epoetin Alfa, Aranesp<sup>®</sup>, Darbepoetin Alfa<sup>®</sup>, Mircera<sup>®</sup>, or Methoxy polyethylene glycol-epotin beta)</li> </ul> <p><b>This benefit is continued on the next page</b></p>	



**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>.

Covered Service	What you pay
<p><b>Medicare Part B drugs (continued)</b></p> <ul style="list-style-type: none"> <li>• IV immune globulin for the home treatment of primary immune deficiency diseases</li> <li>• parenteral and enteral nutrition (IV and tube feeding)</li> </ul> <p><i>[Insert if applicable: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: &lt;URL&gt;.]</i></p> <p>We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit.</p> <p><b>Chapter 5</b> of this <i>Member Handbook</i> explains our drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of this <i>Member Handbook</i> explains what you pay for your drugs through our plan.</p>	




**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>.

Covered Service	What you pay
<p data-bbox="277 289 1084 394"><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered.]</i></p> <p data-bbox="277 415 560 451"><b>Nursing facility care</b></p> <p data-bbox="277 478 1068 590">A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital.</p> <p data-bbox="277 611 1011 678">Services that we pay for include, but aren't limited to, the following:</p> <ul data-bbox="289 699 1019 1627" style="list-style-type: none"> <li>• semiprivate room (or a private room if medically necessary)</li> <li>• meals, including special diets</li> <li>• nursing services</li> <li>• physical therapy, occupational therapy, and speech therapy</li> <li>• respiratory therapy</li> <li>• drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>• blood, including storage and administration</li> <li>• medical and surgical supplies usually given by nursing facilities</li> <li>• lab tests usually given by nursing facilities</li> <li>• X-rays and other radiology services usually given by nursing facilities</li> <li>• use of appliances, such as wheelchairs usually given by nursing facilities</li> </ul> <p data-bbox="505 1654 1089 1690"><b>This benefit is continued on the next page</b></p>	<p data-bbox="1162 289 1336 325"><i>[List copays.]</i></p>



**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>.

Covered Service	What you pay
<p><b>Nursing facility care (continued)</b></p> <ul style="list-style-type: none"> <li>• physician/practitioner services</li> <li>• durable medical equipment</li> <li>• dental services, including dentures</li> <li>• vision benefits</li> <li>• hearing exams</li> <li>• chiropractic care</li> <li>• podiatry services</li> </ul> <p>You 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:</p> <ul style="list-style-type: none"> <li>• a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul>	
<p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p> <p><a href="#">[List any additional benefits offered.]</a></p>	<p><b>\$0</b></p> <p><a href="#">[List copays for additional benefits.]</a></p>



**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>.

Covered Service	What you pay
<p><b>Opioid treatment program (OTP) services</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services:</p> <ul style="list-style-type: none"> <li>• intake activities</li> <li>• periodic assessments</li> <li>• medications approved by the FDA and, if applicable, managing and giving you these medications</li> <li>• substance use counseling</li> <li>• individual and group therapy</li> <li>• testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>[List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation.]</i></p>	\$0



**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>.



Covered Service	What you pay
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>• surgical supplies, such as dressings</li> <li>• splints, casts, and other devices used for fractures and dislocations</li> <li>• lab tests</li> <li>• blood, including storage and administration</li> <li>• diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition</li> <li>• other outpatient diagnostic tests</li> </ul> <p><i>[Plans can include other covered tests as appropriate.]</i></p>	<p>\$0</p>



**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>.

Covered Service	What you pay
<p><b>Outpatient hospital observation</b></p> <p>We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at <a href="https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a></p>	<p>\$0</p>



**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>.

Covered Service	What you pay
<p><b>Outpatient hospital services</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> <li>o Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li> <li>o Sometimes you can be in the hospital overnight and still be “outpatient.”</li> <li>o You can get more information about being inpatient or outpatient in this fact sheet: <a href="https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a>.</li> </ul> </li> <li>• Labs and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies, such as splints and casts</li> <li>• Preventive screenings and services listed throughout the Benefits Chart</li> <li>• Some drugs that you can’t give yourself</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
<p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient mental health care</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• a state-licensed psychiatrist or doctor</li> <li>• a clinical psychologist</li> <li>• a clinical social worker</li> <li>• a clinical nurse specialist</li> <li>• a licensed professional counselor (LPC)</li> <li>• a licensed marriage and family therapist (LMFT)</li> <li>• a nurse practitioner (NP)</li> <li>• a physician assistant (PA)</li> <li>• any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
<p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Outpatient rehabilitation services</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p>	<p>\$0</p>



**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>.

Covered Service	What you pay
<p><b>Outpatient substance use disorder services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• alcohol misuse screening and counseling</li> <li>• treatment of drug abuse</li> <li>• group or individual counseling by a qualified clinician</li> <li>• subacute detoxification in a residential addiction program</li> <li>• alcohol and/or drug services in an intensive outpatient treatment center</li> <li>• extended-release Naltrexone (vivitrol) treatment</li> </ul> <p><i>[Modify this list accurately describe benefits offered or add any additional benefits offered.]</i></p>	<p><i>[List copays.]</i></p>
<p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p><b>Note:</b> If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p>	<p>\$0</p>



**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>.

Covered Service	What you pay
<p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Partial hospitalization services and intensive outpatient services</b></p> <p><b>Partial hospitalization</b> is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital.</p> <p><b>Intensive outpatient service</b> is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.</p> <p><i>[Plans that don't have an in-network community mental health center can add: Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.]</i></p>	\$0



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Covered Service	What you pay
<p><b>Physician/provider services, including doctor's office visits</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• medically necessary health care or surgery services given in places such as:</li> <li>• physician's office</li> <li>• certified ambulatory surgical center</li> <li>• hospital outpatient department</li> <li>• consultation, diagnosis, and treatment by a specialist</li> <li>• basic hearing and balance exams given by your <i>[insert as applicable: primary care provider or specialist]</i>, if your doctor orders them to find out whether you need treatment</li> <li>• <i>[Insert if providing any additional telehealth benefits consistent with 42 CFR § 422.135 in the plan's approved Plan Benefit Package submission: Certain telehealth services, including [insert general description of covered additional telehealth benefits (i.e., the specific Medicare Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider isn't in the same location as the member). Plans may refer members to its medical coverage policy here].</i></li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. <i>[Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.]</i></li> <li>o <i>[List the available means of electronic exchange used for each Medicare Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]</i></li> <li>• <i>[Insert if the plan's service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act: Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare]</i></li> <li>• telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li> <li>• telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li> <li>• telehealth services for members with a substance use disorder or co-occurring mental health disorder</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	



**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>.



Covered Service	What you pay
<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>o You have an in-person visit within 6 months prior to your first telehealth visit</li> <li>o You have an in-person visit every 12 months while receiving these telehealth services</li> <li>o Exceptions can be made to the above for certain circumstances</li> </ul> </li> <li>• telehealth services for mental health visits provided by rural health clinics and federally qualified health centers.</li> <li>• virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>o you're not a new patient <b>and</b></li> <li>o the check-in isn't related to an office visit in the past 7 days <b>and</b></li> <li>o the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b>: <ul style="list-style-type: none"> <li>o you're not a new patient <b>and</b></li> <li>o the evaluation isn't related to an office visit in the past 7 days <b>and</b></li> <li>o the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> </ul> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	





**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>.

Covered Service	What you pay
<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient</li> <li>• Second opinion <i>[insert if appropriate: by another network provider]</i> before surgery</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	
<p><b>Podiatry services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>• routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
 <p><b>Pre-exposure prophylaxis (PrEP) for HIV prevention</b></p> <p>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> <li>• FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.</li> <li>• Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.</li> <li>• Up to 8 HIV screenings every 12 months.</li> <li>• A one-time hepatitis B virus screening.</li> </ul>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>
 <p><b>Prostate cancer screening exams</b></p> <p><i>[Plans that cover men under age 65 must include: For men aged 50 and over,]</i> we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• a digital rectal exam</li> <li>• a prostate specific antigen (PSA) test</li> </ul> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>





**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>.

Covered Service	What you pay
<p><i>[Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]</i></p> <p><b>Prosthetic and orthotic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. These include but aren't limited to:</p> <ul style="list-style-type: none"> <li>• testing, fitting, or training in the use of prosthetic and orthotic devices</li> <li>• colostomy bags and supplies related to colostomy care</li> <li>• pacemakers</li> <li>• braces</li> <li>• prosthetic shoes</li> <li>• artificial arms and legs</li> <li>• breast prostheses (including a surgical brassiere after a mastectomy)</li> </ul> <p>We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p>	<p>\$0</p>
<p><b>Pulmonary rehabilitation services</b></p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have <i>[insert as appropriate: a referral or an order]</i> for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
 <p><b>Screening for Hepatitis C Virus infection</b></p> <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> <li>• You're at high risk because you use or have used illicit injection drugs.</li> <li>• You had a blood transfusion before 1992.</li> <li>• You were born between 1945-1965.</li> </ul> <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	
 <p><b>Sexually transmitted infections (STIs) screening and counseling</b></p> <p>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered <i>[plans that cover women under age 65 should include: for pregnant women and]</i> for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We 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. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p> <p><i>[Also list any additional benefits offered.]</i></p>	<p><b>\$0</b></p> <p><i>[List copays for additional benefits.]</i></p>




**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>.

Covered Service	What you pay
<p><b>Skilled nursing facility (SNF) care</b></p> <p>For a definition of skilled nursing facility care, go to <b>Chapter 12</b>.</p> <p><i>[List days covered and any restrictions that apply, including whether any prior hospital stay is required.]</i> We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• a semi-private room, or a private room if it's medically necessary</li> <li>• meals, including special diets</li> <li>• skilled nursing services</li> <li>• physical therapy, occupational therapy, and speech therapy</li> <li>• drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li> <li>• blood, including storage and administration</li> <li>• medical and surgical supplies given by SNFs</li> <li>• lab tests given by SNFs</li> <li>• X-rays and other radiology services given by nursing facilities</li> <li>• appliances, such as wheelchairs, usually given by nursing facilities</li> <li>• physician/provider services</li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



**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>.

Covered Service	What you pay
<p><b>Skilled nursing facility (SNF) care (continued)</b></p> <p>You usually get SNF care from network facilities. Under certain conditions 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:</p> <ul style="list-style-type: none"> <li>• a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li> <li>• a nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li> </ul>	
<p> <b>Smoking and tobacco use cessation</b></p> <p>Counseling to quit smoking and tobacco use is covered on an outpatient and hospitalized basis for people who meet these criteria:</p> <ul style="list-style-type: none"> <li>• use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease</li> <li>• are competent and alert during counseling</li> <li>• a qualified physician or other Medicare-recognized practitioner provides counseling</li> </ul> <p>We cover two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).</p> <p><i>[List any additional benefits offered.]</i></p>	<p>\$0</p> <p><i>[List copays for supplemental benefits.]</i></p>
<p><i>[If this benefit isn't applicable, plans should delete this row.]</i></p> <p><b>Special Supplemental Benefits for the Chronically Ill</b></p> <p><i>[Enrollees with chronic condition(s) that meet certain criteria may be eligible for supplemental benefits for the chronically ill. The chronic conditions and benefits must be listed here. The benefits listed here must be approved in the bid. Describe the nature of the benefits and eligibility criteria here.]</i></p>	<p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
<p><b>Supervised exercise therapy (SET)</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) <i>[insert if applicable: who have a referral for PAD from the physician responsible for PAD treatment]</i>.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"> <li>• up to 36 sessions during a 12-week period if all SET requirements are met</li> <li>• an additional 36 sessions over time if deemed medically necessary by a health care provider</li> </ul> <p>The SET program must be:</p> <ul style="list-style-type: none"> <li>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li> <li>• in a hospital outpatient setting or in a physician's office</li> <li>• delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li> <li>• under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li> </ul>	<p>\$0</p>




**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>.



Covered Service	What you pay
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> <li>• a non-emergency that requires immediate medical care, <b>or</b></li> <li>• an unforeseen illness, <b>or</b></li> <li>• an injury, <b>or</b></li> <li>• a condition that needs care right away.</li> </ul> <p>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 can't get to a network provider because given your time, place, or circumstances, it's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency).</p> <p><i>[Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]</i></p>	<p>\$0</p>




**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>.

Covered Service	What you pay
 <p><i>[Plans should modify this section to reflect Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]</i></p> <p><b>Vision care</b></p> <p>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> <li>• people with a family history of glaucoma</li> <li>• people with diabetes</li> <li>• African-Americans <i>[plans that cover under 65 must include: who are 50 and over]</i></li> <li>• Hispanic Americans <i>[plans that cover under 65 must include: who are 65 and over]</i></li> </ul> <p>For people with diabetes, we pay for screening for diabetic retinopathy once per year.</p> <p><i>[Plans should modify this description if the plan offers more than is covered by Medicare.]</i> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.</p>	<p><i>[List copays.]</i></p> <p><i>[List copays for additional benefits.]</i></p>



**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>.

Covered Service	What you pay
 <p><b>“Welcome to Medicare” preventive visit</b></p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> <li>• a review of your health,</li> <li>• education and counseling about preventive services you need (including screenings and shots), <b>and</b></li> <li>• referrals for other care if you need it.</li> </ul> <p><b>Note:</b> 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.</p>	\$0

## E. Extra “Optional Supplemental” benefits you can buy

*[Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what’s covered under Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook.]*

Our plan offers some extra benefits that aren’t covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits.**” If you want these optional supplemental benefits, you must sign up for them *[insert if applicable: and you may have to pay an additional premium for them.]* The optional supplemental benefits described in *[insert as applicable: this section OR the enclosed insert]* are subject to the same appeals process as any other benefits.

*[Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next open enrollment period).]*

## F. Our plan’s visitor or traveler benefits



**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>.

*[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 about getting the out-of-area coverage, including the impact based on Medicaid requirements. 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're out of the plan's service area for more than 6 months at a time but don't permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program *[specify areas where the visitor/traveler program is being offered]* that allows you to stay enrolled in our plan when you're outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you're in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don't return to our plan's service area by <end date>, we'll end your membership in our plan.]

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## G. Benefits covered outside of our plan

*[Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate.]*

We don't cover the following services, but they're available through Medicaid program name.

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## H. Benefits not covered by our plan, Medicare, or **[Medicaid program name]**

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medicaid don't pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn't cover the following items and services:



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*[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, are required to be covered by Medicaid or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans can add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans can also add exclusions as needed.]*

- services considered not “reasonable and medically necessary”, according Medicare and <Medicaid program name> standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- *[Plans should delete this if the state allows:]* meals delivered to your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it’s needed because of an accidental injury or to improve a part of the body that isn’t shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**



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- 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 delete this if supplemental:]* regular hearing exams, hearing aids, or exams to fit hearing aids
- *[Plans delete this if supplemental:]* radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. *[Zero cost-sharing plans can adjust this language as applicable]* 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'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.



**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>.