Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services <plan name> 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 the *Member Handbook*.

[Plan should refer members to other parts of the handbook using the appropriate chapter number and section. For example, “refer to Chapter 9, Section A.” An instruction [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[Plan 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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# Your covered services

This chapter tells you what services <plan name> pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 [plan may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.] [Plan may insert reference, as applicable.]

If you get or become eligible for long-term services and supports (LTSS), you may be required to pay part of the cost of these services. This is known as “cost-share,” and the amount is determined by Rhode Island Medicaid. If you are not getting or are not eligible to get LTSS, you pay nothing for your covered services as long as you follow the plan’s rules. Refer to Chapter 3 [plan may insert reference, as applicable] for details about the plan’s rules.

If you need help understanding what services are covered, call your [plan may insert: care manager and/or Member Services] at <toll-free number>. [Plan should include any other contact information.]

[*As applicable, plans include the following subsection heading, a similar update to the Table of Contents, and information as indicated below*. *This section is optional.*]

## A1. During public health emergencies

[*Any plan providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describes the coverage and flexibilities here or includes general information about the coverage and flexibilities along with any cross references, as applicable. The plan includes whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. The plan also includes any specific contact information, as applicable, where members can get more details.*]

# Rules against providers charging you for services

We do not allow <plan name> providers to bill you for 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[plan may insert reference, as applicable] or call Member Services. The only exception to this is if you are getting LTSS and Rhode Island Medicaid says that you have to pay part of the cost of these services.

# Our plan’s Benefits Chart

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

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. [If the plan includes an index at the end of the chapter, it should insert: To find a service in the chart, you can also use the index at the end of the chapter.]

**We will pay for the services listed in the Benefits Chart only when the following rules are met.** Unless you are getting or are eligible for long-term services and supports (LTSS), you do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below. If you get or become eligible for LTSS, you may be required to pay part of the cost of these services. This is known as “cost-share,” and the amount is determined by Rhode Island Medicaid.

* Your Medicare and Rhode Island Medicaid covered services must be provided according to the rules set by Medicare and Rhode Island Medicaid.
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need medical, surgical, or other services 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 home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary includes services to prevent a health-related condition from getting worse.
* For new enrollees, the plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
* You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 [plan may insert reference, as applicable] has more information about using network and out-of-network providers.
* You have a primary care provider (PCP) or a care team that is providing and managing your care. [If the plan does not require referrals, omit the rest of this paragraph:] In most cases, your PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan’s network. This is called a referral. Chapter 3 [plan may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.
* Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Covered services that need PA are marked in the Benefits Chart [insert as appropriate: by an asterisk (\*) **or** by a footnote **or** in bold type **or** in italic type]. [Insert if applicable: In addition, you must get PA first for the following services that are not listed in the Benefits Chart: [insert list].]
* [*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.]
* [Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI)”* in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost sharing]:
  + [List all applicable chronic conditions here.]
  + [If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill member eligible for SSBCI.]

Please refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]

* You will find this apple Apple icon represents preventive services next to preventive services in the Benefits Chart.

[Instructions on completing the Benefits Chart:

* For all preventive care and screening test benefit information, if the plan covers a richer benefit, there is no need to include the given description (unless it is still applicable) and may instead describe the plan benefit.
* Include the following where appropriate: You should talk to your provider and get a referral.
* The plan must include any services provided in excess of the Medicare and Rhode Island Medicaid requirements. Preventive services must be identified with the apple icon.
* The plan should clearly indicate which benefits are subject to PA. (This can be done with asterisks, footnotes, bold type, or italic type. The plan should 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.)
* The plan may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Benefits Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* The plan must describe any restrictive policies, limitations, or monetary limits that might affect a member’s access to services within the chart.
* The plan may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.
* Plan should include all non-waiver LTSS in the chart in alphabetical order.
* All HCBS waiver services should be appended to the end of the chart.
* Plan offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
  + Deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the “Uniformity Flexibility” benefits for which they are 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.]

# The Benefits Chart

[When a benefit continues from one page to the next, plan enters 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, plan enters the benefit name again in bold followed by **(continued)**. Plan may refer to**Durable medical equipment (DME) and related supplies** and other examples later in this chart as examples. Plan 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.]

| **Services that our plan pays for** | | **What you must pay** |
| --- | --- | --- |
| Apple icon in the benfits chart showing preventive service | Abdominal aortic aneurysm screening  The plan will pay for a one-time ultrasound screening for people at risk. The 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.  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this as necessary.]  Abortion  The plan will not pay for an abortion except in cases of rape or incest or if the pregnancy threatens the life of the mother. | $0 |
|  | Acupuncture for chronic low back pain  The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as:   * lasting 12 weeks or longer; * not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); * not associated with surgery; **and** * not associated with pregnancy.   The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year.  Acupuncture treatments must be stopped if you don’t get better or if you get worse.  [*List any additional benefits offered.*] | $0 |
|  | Adult Day Services  The plan will pay for adult day services.  [List any additional benefits offered, including different levels of service available.] | $0 |
| Apple icon in the benfits chart showing preventive service | Alcohol misuse screening and counseling  The plan will pay for alcohol-misuse screening.  If you screen positive for alcohol misuse, the plan covers counseling sessions with a qualified provider or practitioner.  [List any additional benefits offered.] | $0 |
|  | Ambulance services  Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care.  Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan.  In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. | $0 |
| Apple icon in the benfits chart showing preventive service | Annual wellness visit  The plan will pay for an annual checkup once every 12 months. This is to make or update a prevention plan based on your current risk factors. | $0 |
| Apple icon in the benfits chart showing preventive service | Bone mass measurement  The plan will pay for certain procedures for Members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.  The plan will also pay for a provider to look at and comment on the results.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Breast cancer screening (mammograms)  The plan will pay for mammograms and clinical breast exams.  [List any additional benefits offered.] | $0 |
|  | Cardiac (heart) rehabilitation services  The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a provider’s [insert as appropriate: referral **or** order].  The plan also covers intensive cardiac rehabilitation programs, which are more intense than standard cardiac rehabilitation programs. | $0 |
| Apple icon in the benfits chart showing preventive service | Cardiovascular (heart) disease risk reduction visits (therapy for heart disease)  The plan pays for visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may:  discuss aspirin use,  check your blood pressure, **or**  give you tips to make sure you are eating well.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Cardiovascular (heart) disease testing  The plan pays for blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Cervical and vaginal cancer screening  The plan will pay for pap tests and pelvic exams.  [List any additional benefits offered.] | $0 |
|  | Chiropractic services  The plan will pay for the following services:  adjustments of the spine to correct alignment  [List any Rhode Island Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits.] | $0 |
| Apple icon in the benfits chart showing preventive service | Colorectal cancer screening  The plan will pay for the following services:   * Colonscopy 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 are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. * Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. * Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. * Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. * Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. * Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. * Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.   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.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Counseling to stop smoking or tobacco use  If you use tobacco, the plan will pay for face-to-face counseling to help you stop smoking or using tobacco.  The plan will also pay for telephone counseling and support.  [List any additional benefits offered.] | $0 |
|  | [Plans should modify this row to accurately describe the supplemental benefit offered.]  Dental services  Please see section F2 of this chapter for routine dental care that is covered by Rhode Island Medicaid.  <Plan name> will pay for the following services:  [List any plan-covered supplemental benefits offered, such as routine dental care, dental X-rays, and cleanings.]  We pay for some dental services when the service is an integral part of specific treatment of a beneficiary’s primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. | [List copays.] |
| Apple icon in the benfits chart showing preventive service | Depression screening  The plan will pay for depression screening. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Diabetes screening  The plan will pay for diabetes screening (includes fasting glucose tests).  You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Diabetic self-management training, services, and supplies  The plan will pay for the following services for all people who have diabetes (whether they use insulin or not):  Supplies to monitor your blood glucose, including the following:   * a blood glucose monitor * blood glucose test strips * lancet devices and lancets * glucose-control solutions for checking the accuracy of test strips and monitors   For people with diabetes who have severe diabetic foot disease, the plan will pay for the following:   * One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** * One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)   The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.  The plan will pay for training to help you manage your diabetes, in some cases.  [List any additional benefits offered.] | $0 |
|  | Doula Services  Prenatal and post-partum care is covered for pregnant women and new mothers. The following are examples of doula services covered:  services to support pregnant members, improve birth outcomes, and support new mothers  advocating for and supporting breastfeeding and infant care  providing resources, education, care, and emotional support for the member after pregnancy ends  support for the member and family during the post-partum recovery  Other services may be covered.  The plan will pay for six (6) visits per pregnancy for prenatal and post-partum care and one (1) labor and delivery visit. |  |
|  | [If the plan covers durable medical equipment as a Rhode Island Medicaid benefit, modify the following description if necessary.]  Durable medical equipment (DME) and related supplies  (For a definition of “Durable medical equipment (DME),” refer to Chapter 12 [plan may insert reference, as applicable] as well as Chapter 3, Section M of this handbook.)  The following are examples of DME items that are covered:  wheelchairs  crutches  powered mattress systems  diabetic supplies  hospital beds ordered by a provider for use in the home  intravenous (IV) infusion pumps  speech generating devices  oxygen equipment and supplies  nebulizers  walkers  Other items may be covered.  [If the plan does not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Rhode Island Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  [If the plan limits the DME brands and manufacturers that you will cover, insert the following (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.): With this Member Handbook, we sent you <plan name>’s list of DME. The list tells you the brands and makers of DME that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  **This benefit is continued on the next page** | $0 |
|  | Durable medical equipment (DME) and related supplies (continued)  Generally, <plan name> covers any (DME) covered by Medicare and Rhode Island Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to <plan name> and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your provider to decide what brand is medically right for you after this 90-day period. (If you disagree with your provider, you can ask them to refer you for a second opinion.)  If you (or your provider) do not agree with the plan’s coverage decision, you or your provider may file an appeal. You can also file an appeal if you do not agree with your provider’s decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9 [plan may insert reference, as applicable].)] |  |
|  | Emergency care  Emergency care means services that are:  given by a provider trained to give emergency services, **and**  needed to treat a medical emergency.  A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:  serious risk to your health or to that of your unborn child; **or**  serious harm to bodily functions; **or**  serious dysfunction of any bodily organ or part; **or**  in the case of a pregnant woman in active labor, when:   * there is not enough time to safely transfer you to another hospital before delivery. * a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.   The plan will pay for emergency care and emergency transportation services.  [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.] | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plan should insert information as needed to accurately describe emergency care benefits:(e.g., you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay).] |
|  | Environmental or home modifications  The plan will pay for changes to your home or vehicle to help you live safely at home. The following are examples of services that are covered:   * grab bars * shower chairs * eating utensils * raised toilet seats * wheelchair ramps * standing poles   Other services may also be covered. | $0 |
|  | [Plan should modify this as necessary.]  Family planning services  The law lets you choose any provider – whether a network provider or out-of-network provider – to get certain family planning services from. This means you can get family planning services from any network or out-of-network provider, clinic, hospital, pharmacy, or family planning office.  The plan will pay for the following services:  family planning exam and medical treatment  family planning lab and diagnostic tests  family planning methods (birth control pills, patch, ring, IUD, injections, implants)  family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)  counseling and diagnosis of infertility, and related services  counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions  treatment for sexually transmitted infections (STIs)  **This benefit is continued on the next page** | $0 |
|  | Family planning services (continued)  voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)  genetic counseling  The plan will also pay for some other family planning services. However, you must use a provider in the plan’s network for the following services:  treatment for AIDS and other HIV-related conditions, including medical case management for people living with HIV/AIDS and non-medical care management services for people living with HIV/AIDS or are at risk for HIV  genetic testing |  |
| Apple icon in the benfits chart showing preventive service | [If this benefit is not applicable, plan should delete this row.]  Health and wellness education programs  [These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of Members include weight management, fitness, and stress management. Describe the nature of the programs here.] | $0 |
|  | [If the plan covers hearing services as a Rhode Island Medicaid benefit, modify the following description if necessary. Add the apple icon if listing only preventive services.]  Hearing services  The plan pays for routine hearing exams and hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  The plan also covers hearing aids and evaluations for fitting hearing aids once every three years.  [List any additional benefits offered.] | $0 |
|  | [If this benefit is not applicable, plan should delete this row.]  Help with certain chronic conditions  [Plan that offers targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI),”* which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost sharing. If offering SSBCI, plan must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.] | [List copays.] |
| Apple icon in the benfits chart showing preventive service | HIV screening  The plan pays for HIV screening exams and HIV screening tests. The plan will also pay for medical case management for people living with HIV/AIDS and non-medical care management services for people living with HIV/AIDS or who are at risk for HIV.  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Home care services  The plan will pay for personal care services, such as help with dressing and eating, and homemaking services, such as laundry and shopping. Home care services do not include respite care or day care.  The plan may also pay for other services not listed here.  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Home health agency care  Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency.  The plan will pay for the following services:  full-time, part-time or intermittent skilled nursing, certified nursing assistant, and home health aide services  physical therapy, occupational therapy, and speech therapy  medical and social services  medical equipment and supplies  The plan may also pay for other services not listed here. | $0 |
|  | **Home infusion therapy**  The plan will pay 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:   * the drug or biological substance, such as an antiviral or immune globulin; * equipment, such as a pump; **and** * supplies, such as tubing or a catheter.   The plan will cover home infusion services that include but are not limited to:   * professional services, including nursing services, provided in accordance with your care plan; * member training and education not already included in the DME benefit; * remote monitoring; **and** * monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.   [List any additional benefits offered.] | [List copays.]  [List copays for additional benefits.] |
|  | Hospice care  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. The plan must help you find a hospice program certified by Medicare. Your hospice provider can be a network provider or an out-of-network provider.  The plan will pay for the following while you are getting hospice services:  drugs to treat symptoms and pain  short-term respite care  home care  This benefit is continued on the next page |  |
|  | Hospice care (continued)  **Hospice services and services covered by Medicare Part A or B are billed to Medicare.**  Refer to Section F of this chapter for more information.  **For services covered by <plan name> but not covered by Medicare Part A or B:**  <Plan name> will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay [insert as appropriate: the plan’s cost sharing amount **or** nothing] for these services.  For drugs that may be covered by <plan name>’s Medicare Part D benefit:  Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plan may insert reference, as applicable].  **Note:** If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plan should include a phone number or other contact information.]  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
| Apple icon in the benfits chart showing preventive service | Immunizations  The plan will pay for the following services:  pneumonia vaccine  flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary  hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B  COVID-19 vaccine  other vaccines if you are at risk and they meet Medicare Part B or Rhode Island Medicaid coverage rules  The plan will pay for other vaccines that meet the Rhode Island Medicaid or Medicare Part D coverage rules. Read Chapter 6 [plan may insert reference, as applicable] to learn more.  [List any additional benefits offered.] | $0 |
|  | Inpatient hospital care  [List any restrictions that apply.]  The plan will pay for medically necessary inpatient hospital care. The plan covers the following services:  semi-private room (or a private room if it is medically necessary)  meals, including special diets  regular nursing services  costs of special care units, such as intensive care or coronary care units  drugs and medications  lab tests and other diagnostic tests  X-rays and other radiology services, including technician materials and services  needed surgical and medical supplies  appliances, such as wheelchairs  **This benefit is continued on the next page** | $0  You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. |
|  | Inpatient hospital care (continued)  operating and recovery room services  physical, occupational, and speech therapy  inpatient substance use treatment services  blood, including storage and administration   * The plan will pay for whole blood, packed red cells and all other parts of blood.   physician services  transplants, including corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. Other types of transplants may be covered.  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plan 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 <plan name> provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.]  [Plan may further define the specifics of transplant travel coverage.] |  |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Inpatient services in a psychiatric hospital  The plan will pay for mental health care services that require a hospital stay. | $0 |
|  | Kidney disease services and supplies  The plan will pay for the following services:  kidney disease education services to teach kidney care and help Members make good decisions about their care.   * you must have stage IV chronic kidney disease, and your provider must refer you * the plan will cover up to six sessions of kidney disease education service   outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plan may insert reference, as applicable]*,* or when your provider for this service is temporarily unavailable or inaccessible  inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care  self-dialysis training, including training for you and anyone helping you with your home dialysis treatments  home dialysis equipment and supplies  certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply  Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart. | $0 |
| Apple icon in the benfits chart showing preventive service | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:  are aged 50-77, **and**  have a counseling and shared decision-making visit with your doctor or other qualified provider, **and**  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.  After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | Medicare Diabetes Prevention Program (MDPP)  The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:  long-term dietary change, **and**  increased physical activity, **and**  ways to maintain weight loss and a healthy lifestyle. | $0 |
|  | Medicare Part B prescription drugs  [*If the plan will or expects to use Part B step therapy, the plan should indicate the Part B drug categories below that will or may be subject to Part B step therapy as well as a link to a list of drugs that will be subject to Part B step therapy. The link may be updated throughout the year and any changes added at least 30 days prior to implementation per 42 CFR 422.111(d).*]  These drugs are covered under Part B of Medicare. <Plan name> will pay for the following drugs:  drugs you don’t usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services  insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)  other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan  the Alzheimer’s drug, Leqembi (generic lecanemab) which is given intravenously (IV)  clotting factors you give yourself by injection if you have hemophilia  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 does not cover them if you were enrolled in Medicare Part A at the time of the organ transplant  osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a provider certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself   * 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   **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B prescription drugs (continued)**  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  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  certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it  calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv and the oral medication Sensipar  certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics   * erythropoiesis-stimulating agents [plan may delete any of the following drugs that are not covered under the plan](such as Epogen®, Procrit®, Retacrit Epoetin Alfa, Aranesp®, or Darbepoetin Alfa, Aranesp, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epotin beta)   IV immune globulin for the home treatment of primary immune deficiency diseases  parenteral and enteral nutrition (IV and tube feeding)  **This benefit is continued on the next page** |  |
|  | **Medicare Part B prescription drugs (continued)**  [Insert if applicable: The following link will take you to a list of Part B drugs that may be subject to step therapy: <URL>.]  We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.  Chapter 5 [plan may insert reference, as applicable] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [plan may insert reference, as applicable] explains what you pay for your outpatient prescription drugs through our plan. |  |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Nursing facility care | [List copays.]  If you get nursing facility care, you may have to pay part of the cost of your services. This is known as “cost-share,” and the amount is determined by Rhode Island Medicaid. |
|  | Nutritional/dietary benefit  The plan will pay for medical nutrition therapy and counseling delivered by a licensed dietician to help you manage a chronic condition or medical problem such as diabetes, high blood pressure, obesity, or cancer. The plan will also pay for medical nutrition therapy and counseling if you are taking a medication that can affect your body’s ability to absorb nutrients or your metabolism.  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Obesity screening and therapy to keep weight down  The plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care providerto find out more.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Opioid treatment program (OTP) services  The plan will pay for the following services to treat opioid use disorder (OUD):  intake activities  periodic assessments  medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications  substance use disorder counseling  individual and group therapy  testing for drugs or chemicals in your body (toxicology testing)  [List any additional benefits offered, with the exception of meals and transportation.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  The plan will pay for the following services:  X-rays  radiation (radium and isotope) therapy, including technician materials and supplies  surgical supplies, such as dressings  splints, casts, and other devices used for fractures and dislocations  incontinence supplies, such as diapers, underpads, and liners [Plan may move incontinence supplies to a more appropriate category in the Benefits Chart if it would like to do so.]  lab tests  blood and blood storage and administration  other outpatient diagnostic tests  The plan may also pay for other services not listed here.  [Plan can include other covered tests as appropriate.] | $0 |
|  | Outpatient hospital services  The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  The plan will pay for the following services:  services in an emergency department or outpatient clinic, such as outpatient surgery or observation services   * + Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.”   + Sometimes you can be in the hospital overnight and still be an “outpatient.”   + You can get more information about being an inpatient or an outpatient in this fact sheet: [www.medicare.gov/media/11101](https://www.medicare.gov/media/11101)   labs and diagnostic tests billed by the hospital  mental health care, including care in a partial-hospitalization program, if a provider certifies that inpatient treatment would be needed without it  X-rays and other radiology services billed by the hospital  medical supplies, such as splints and casts  preventive screenings and services listed throughout the Benefits Chart  some drugs that you can’t give yourself  The plan may also pay for other services not listed here.  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient mental health care  The plan will pay for mental health services provided by:  community mental health centers,  a state-licensed psychiatrist or doctor,  a clinical psychologist,  a clinical social worker,  a clinical nurse specialist,  a licensed professional counselor (LPC),  a licensed marriage and family therapist (LMFT),  a nurse practitioner (NP),  a physician assistant, **or**  any other Medicare- or Rhode Island Medicaid-qualified mental health care professional as allowed under applicable state laws.  The plan will pay for the following:  clinic services  individual, group, and family treatment  crisis intervention and stabilization  emergency services  diagnostic evaluation  psychological testing  medication evaluation and management  specialized services for people with serious mental illness, including Integrated Health Home and Assertive Community Treatment  partial hospitalization  day/evening treatment  intensive outpatient treatment  clubhouse  **This benefit is continued on the next page** | $0 |
|  | Outpatient mental health care (continued)  integrated dual diagnosis treatment for people with mental illness and substance use disorders  court-ordered mental health treatment  The plan may also pay for other services not listed here.  [List any additional benefits offered.] |  |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Outpatient rehabilitation services  The plan will pay for physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, and respiratory therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | Outpatient substance use disorder treatment services  The plan will pay for:  substance use counseling  medication-assisted opioid treatment programs, including methadone dosing and counseling and prescriptions for other medications such as suboxone  opioid Treatment Program (OTP) Health Home services, which provide resources to opioid dependent Members who are currently getting or who meet criteria for medication-assisted treatment  medically managed detoxification in a hospital setting or a detoxification program  integrated dual diagnosis treatment for people with mental illness and substance use disorders  court-ordered substance use treatment  The plan may also pay for other services not listed here.  [List any additional benefits offered.] | $0 |
|  | Outpatient surgery  The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | [Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate.]  Partial hospitalization services and intensive outpatient services  Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is 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.  Intensive outpatient service 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 is more intense than the care received in your doctor’s, therapist’s, LMFT, or licensed professional counselor’s office but less intense than partial hospitalization.  [Network plans that do not have an in-network community mental health center may add: Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | Physician/provider services, including doctor’s office visits  The plan will pay for the following services:  medically necessary health care or surgery services given in places such as:   * physician’s office * certified ambulatory surgical center * hospital outpatient department   consultation, diagnosis, and treatment by a specialist   * basic hearing and balance exams given by your [insert as applicable: primary care provider**or** specialist], if your provider orders them to find out whether you need treatment * [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 Part B service(s) the plan has identified as clinically appropriate for offering through electronic exchange when the provider is not in the same location as the member). Plans may refer members to their medical coverage policy here].] * 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. [The plan may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.] * [List the available means of electronic exchange used for each Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]   **This benefit is continued on the next page** | $0 |
|  | Physician/provider services, including doctor’s office visits (continued)   * [*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] * 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 the member’s home * telehealth services to diagnose, evaluate, or treat symptoms of a stroke * telehealth services for members with a substance use disorder or co-occurring mental health disorder * telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:   + you have an in-person visit within 6 months prior to your first telehealth visit   + you have an in-person visit every 12 months while receiving these telehealth services   + exceptions can be made to the above for certain circumstances * telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers * telehealth services provided by qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists * virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:   + you’re not a new patient **and**   + the check-in isn’t related to an office visit in the past 7 days **and**   **This benefit is continued on the next page** |  |
|  | Physician/provider services, including doctor’s office visits (continued)   * + the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment * evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:   + you’re not a new patient **and**   + the evaluation isn’t related to an office visit in the past 7 days **and**   + the evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment * consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient * second opinion [insert if appropriate:by another network provider] before surgery * Non-routine dental and oral health care, including operating room charges and anesthesia services. Covered services are limited to: * surgery of the jaw or related structures, * setting fractures of the jaw or facial bones, * pulling teeth before radiation treatments of neoplastic cancer, **or** * services that would be covered when provided by a physician.   [*List any additional benefits offered.*] |  |
|  | Podiatry services  The plan will pay for the following services:  diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)  routine foot care for Members with conditions affecting the legs, such as diabetes  [List any additional benefits offered.] | $0 |
| Apple icon in the benfits chart showing preventive service | Prostate cancer screening exams  The plan will pay for the following services:  a digital rectal exam  a prostate specific antigen (PSA) test  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Prosthetic and orthotic devices and related supplies  Prosthetic devices replace all or part of a body part or function. These include but are not limited to:  testing, fitting, or training in the use of prosthetic and orthotic devices  colostomy bags and supplies related to colostomy care  pacemakers  braces  prosthetic shoes  artificial arms and legs  breast prostheses (including a surgical brassiere after a mastectomy)  The plan will pay for some supplies related to prosthetic and orthotic devices. They will also pay to repair or replace prosthetic and orthotic devices.  The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section [plan may insert reference, as applicable]for details. | $0 |
|  | Pulmonary rehabilitation services  The plan will pay for pulmonary rehabilitation programs for Members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The Member must have [insert as appropriate:a referral **or** an order]for pulmonary rehabilitation from the doctor or provider treating the COPD.  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Residential mental health and substance use treatment services  The plan will pay for:  short- and long-term mental health treatment residential services.  acute substance use residential treatment  [List any additional benefits offered.] | $0 |
|  | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate.]  Services to prevent a hospital or nursing facility admission  The plan will pay for a limited set of services for people at high risk for a hospitalization or a nursing facility admission, including:  homemaker services, such as meal preparation or routine household care  minor changes to your home, such as grab bars, shower chairs, and raised toilet seats  physical therapy services prior to surgery if the therapy will enhance recovery or reduce rehabilitation time  physical therapy evaluation for home accessibility appliances or devices  [List any additional benefits offered and additional information on how to qualify for the services.] | $0 |
| Apple icon in the benfits chart showing preventive service | Sexually transmitted infections (STIs) screening and counseling  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care providermust order the tests.  The plan will also pay for face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs.  [Also list any additional benefits offered.] | $0 |
|  | Skilled nursing facility (SNF) care  [List days covered and any restrictions that apply, including whether any prior hospital stay is required.]  The plan will pay for the following services:  a semi-private room, or a private room if it is medically necessary  meals, including special diets  nursing services  physical therapy, occupational therapy, and speech therapy  drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors  blood, including storage and administration   * The plan will pay for whole blood, packed red, and all other parts of blood, including storage and administration, beginning with the first pint.   medical and surgical supplies given by nursing facilities  **This benefit is continued on the next page** | $0 |
|  | Skilled nursing facility (SNF) care (continued)  lab tests given by nursing facilities  X-rays and other radiology services given by nursing facilities  appliances, such as wheelchairs, usually given by nursing facilities  physician/provider services  The plan may also pay for other services not listed here.  You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:  a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)  a nursing facility where your spouse or domestic partner lives at the time you leave the hospital |  |
|  | Special medical equipment/minor assistive devices  The plan will pay for special medical equipment and supplies to make it easier for you to do daily activities, such as eating and bathing. | $0 |
|  | Supervised exercise therapy (SET)  The plan will pay for SET for Members with symptomatic peripheral artery disease (PAD) [*insert if applicable:* who have a referral for PAD from the physician responsible for PAD treatment]. The plan will pay for:   * up to 36 sessions during a 12-week period if all SET requirements are met * an additional 36 sessions over time if deemed medically necessary by a health care provider   The SET program must be:   * 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in Members with leg cramping due to poor blood flow (claudication) * in a hospital outpatient setting or in a physician’s office * delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD * under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques | $0 |
|  | Urgently needed care  Urgently needed care is non-emergency care given to treat:  an unforeseen medical illness, **or**  an acute injury, **or**  a condition that needs care right away.  If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your time, place, or circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan’s service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).  [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.] | $0 |
| Apple icon in the benfits chart showing preventive service | [Plan should modify this section to reflect Rhode Island Medicaid or plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  The plan will pay for a routine eye exam and eyeglasses once every two years. Eyeglass lenses are covered more than once every two years only if it is medically necessary. Contact lenses may be covered if you have a visual or ocular condition that is better treated with contact lenses than with eyeglasses.  The plan will pay for outpatient doctor and other provider services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.  For people at high risk of glaucoma, the plan will pay glaucoma screenings. People at high risk of glaucoma include:  people with a family history of glaucoma,  people with diabetes,  African-Americans who are age 50 and older, **and**  Hispanic Americans who are 65 or older.  [Plan should modify this description if the plan offers more than is covered by Medicare.] The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)  [Also list any additional benefits offered, such as supplemental vision exams or glasses.] | $0 |
| Apple icon in the benfits chart showing preventive service | “Welcome to Medicare” Preventive Visit  The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes:  a review of your health,  education and counseling about the preventive services you need (including screenings and shots), **and**  referrals for other care if you need it.  **Note:** 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 provider’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

Our plan also covers long-term services and supports (LTSS) for Members who need them and qualify for LTSS through Rhode Island Medicaid. You may need to pay for part of the cost of the services. This is called “cost-share,” and the amount you pay is determined by Rhode Island Medicaid. [Plan to provide additional information, before the table or in each row of the table, on how to qualify for the services, additional benefits covered and any service exclusions.]

| **LTSS Services** | **What you must pay** |
| --- | --- |
| Assisted living  The plan will pay for services and supports for you to live in an assisted living facility. The plan covers multiple levels of assisted living based on your medical needs. | Determined by Rhode Island Medicaid |
| Community transition services  The plan will provide services to help you move from a nursing facility or institution to a private home. The plan will also pay for some one-time living expenses to help you set up a private home when you move from a nursing facility or institution. | Determined by Rhode Island Medicaid |
| Day supports  The plan will pay for services to help you with self-help and social skills. | Determined by Rhode Island Medicaid |
| Employment supports  The plan will pay for services, such as supervision, transportation, or training, to help you get or keep a paid job. | Determined by Rhode Island Medicaid |
| Homemaker  The plan will pay for homemaker services to help with general householder tasks, such as meal preparation or general household care. | Determined by Rhode Island Medicaid |
| Home Delivered Meals  The plan will pay for up to one meal five days per week to be delivered to your home. | Determined by Rhode Island Medicaid |
| Personal care assistance  The plan will pay for assistance with daily activities in your home or the community if you have a disability and are unable to do the activities on your own. | Determined by Rhode Island Medicaid |
| Private duty nursing  The plan will pay for individual and continuous care provided by licensed nurses in your home. | Determined by Rhode Island Medicaid |
| Rehabilitation services  The plan will pay for specialized physical, occupational, and speech therapy services at outpatient rehabilitation centers. | Determined by Rhode Island Medicaid |
| Residential supports  The plan will pay for services to help you with daily activities to live in your own home, such as learning how to prepare meals and do household chores. | Determined by Rhode Island Medicaid |
| Respite  The plan will pay for short-term or temporary caregiving services when a person who usually cares for you is not available to provide care. | Determined by Rhode Island Medicaid |
| RIte @ Home (Supported Living Arrangements – Shared Living)  The plan will pay for personal care and other services provided by a caretaker who lives in the home. | Determined by Rhode Island Medicaid |
| Self-directed services and supports  If you are enrolled in self-directed care, the plan will pay for:  services, equipment, and supplies that help you live in the community  services to help you direct and pay for your own services | Determined by Rhode Island Medicaid |
| Senior/adult companion  The plan will pay for non-medical help and social support with daily activities, such as meal preparation, laundry, and shopping. | Determined by Rhode Island Medicaid |
| Skilled nursing services  The plan will pay for skilled nursing services. | Determined by Rhode Island Medicaid |

# Our plan’s visitor or traveler benefits

[If the plan offers a visitor/traveler program to members who are out of its service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage.]

# Benefits covered outside of <plan name>

[Plan should modify this section to include additional benefits covered outside the plan *by Medicare fee-for-service and/or Rhode Island Medicaid fee-for-service,* as appropriate.]

The following services are not covered by <plan name> but are available through Medicare [insert if appropriate: or Rhode Island Medicaid].

## F1. Hospice care

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. The plan must help you find Medicare-certified hospice programs. Your hospice provider can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what <plan name> pays for while you are getting hospice care services.

**For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:**

* The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

**For services covered by Medicare Part A or B that are not related to your terminal prognosis:**

* The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

**For drugs that may be covered by <plan name>’s Medicare Part D benefit:**

* Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plan may insert reference, as applicable].

**Note:** If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plan should include a phone number or other contact information.]

## F2. Dental services

[Plan should modify this section to include any supplemental benefits information provided by the plan*,* as appropriate.] Regular dental care, such as cleanings, fillings or dentures, are covered by Rhode Island Medicaid. **For regular dental care, find a provider that accepts Rhode Island Medicaid and use your Rhode Island Medicaid (“anchor”) ID card.** In some cases, dental care required to treat illness or injury may be covered by the plan as inpatient or outpatient care. Call <plan name> at <toll-free number> (TTY: <TTY number>) if you are not sure whether the plan or Rhode Island Medicaid covers the dental services you need or if you need help finding a dentist.

## F3. Non-emergency transportation

You may be eligible for a reduced-fare RIPTA bus pass. To get a reduced-fare RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903 or the RIPTA Customer Service Office at 705 Elmwood Avenue, Providence, RI 02907. Call RIPTA at 1-401-784-9500 (TTY: 1-800-745-5555) for more information or visit [www.ripta.com/reducedfareprogram](http://www.ripta.com/reducedfareprogram).

If you are unable to use a RIPTA bus pass, Rhode Island Medicaid covers non-emergency medical transportation (NEMT) services for rides to medical, dental, or other health-related appointments. If you need routine NEMT, call [Plan should insert telephone number and hours of operation of the State’s NEMT vendor], or <plan name> at <toll-free number> (TTY: <TTY number>). **When scheduling NEMT,** **use your Rhode Island Medicaid (“anchor”) ID card.** [Plan should insert any additional options for scheduling NEMT.]

**You may ask for urgent care transportation 24 hours a day, 7 days a week.** Schedule transportation for non-urgent care **at least** 48 hours before your appointment.

| **Call to schedule on:** | **If you need a ride on:** |
| --- | --- |
| Monday | Wednesday |
| Tuesday | Thursday |
| Wednesday | Friday, Saturday, or Sunday |
| Thursday | Monday |
| Friday | Tuesday |

[Plan should add additional information on accessing transportation services as needed.]

## F4. Residential services for people with intellectual and developmental disabilities

Residential services for people with intellectual and developmental disabilities are covered by Rhode Island Medicaid. Call <plan name> at <toll-free number> (TTY: <TTY number>) if you are unsure whether the services you need are covered by the plan or Rhode Island Medicaid.

## F5. Home stabilization services

If you are homeless, at risk for becoming homeless, or moving from a nursing facility to the community, you may be able to get services from Rhode Island Medicaid to help you with housing-related problems. If you have questions about the services that Rhode Island Medicaid covers or if you would like a referral to this program, call <plan name> at <toll-free number>, (TTY: <TTY number>).

# Benefits not covered by <plan name>, Medicare, or Rhode Island Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not pay for these benefits. Medicare and Rhode Island Medicaid will not pay for them either.

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

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9 [plan may insert reference, as applicable].

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

[The services listed in the remaining bullets are excluded from Medicare’s and Rhode Island Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Rhode Island Medicaid or under a State’s demonstration, or have become covered due to a Medicare or Rhode Island Medicaid change in coverage policy, delete them from this list. When the plan partially excludes services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plan may add parenthetical references to the Benefits Chart for descriptions of covered services/items as appropriate. Plan may also add exclusions as needed.]

* Services considered not “reasonable and necessary,” according to the standards of Medicare and Rhode Island Medicaid, unless these services are listed by our plan as covered services.
* Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 [plan may insert reference, as applicable] for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
* Surgical treatment for morbid obesity, except when it is medically necessary, and Medicare or Rhode Island Medicaid pays for it.
* gym memberships
* A private room in a hospital, except when it is medically necessary.
* Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
* [Plan should delete this if State allows for this:] Fees charged by your spouse or domestic partner, guardian, or legal representative.
* 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 is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* 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.
* [Plan should 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. However, when a veteran gets emergency services at a VA hospital and there is VA cost sharing, we will reimburse the veteran for the amount they paid.