COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

Benefit or Service	Prior Authorization	Member Cost Share Same as Original Medicare for Medicare covered services. These services may also be subject to annual Part A & B deductible in addition to copays and coinsurance. Submit cost shares to Medicaid.	Additional Information
Abdominal Aortic Aneurysm Screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Acupuncture - Medicare Covered for Chronic Back Pain		20% Coinsurance	•Medicare criteria must be met. •Up to 12 visits in 90 days. •8 additional sessions will be covered if improvement is demonstrated from the initial 12 visits •No more than 20 visits in a calendar year.
Alternative Medicine: Acupuncture and Naturopathy and Non-Medicare Chiropractor		0% coinsurance	New limit: 12 visit limit which is a combination of visits from Acupuncturists, Naturopaths and Chiropractor visits not covered by Medicare. X-rays perfomed by a Chiropractor are not covered. Massage therapy is not covered.
AIR Ambulance (Non-emergency)	Yes	20% Coinsurance	Covered, provided Medicare criteria are met.
Ambulance (Emergency)		20% Coinsurance	Covered, including air ambulance, provided Medicare criteria are met.
Ambulance (Non-Emergency)		20% Coinsurance	Covered, provided Medicare criteria are met.
Anesthesiologist (Anesthesia)		$0 copay	For professional services.

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Annual Wellness Visit/AWV (Also, see Welcome to Medicare Preventive Visit)		$0 copay	All Medicare members who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received a Welcome to Medicare Visit (AWV or Initial Preventive Physical Exam/IPPE) within the past 12 months
Bone mass measurement (Bone Density)	PA Required if more often than once every 2 years.	$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. CMS limitations apply, every 2 years; or more frequently if medically necessary.
Breast cancer screening (mammograms, mammography)		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for age 40 and older • Clinical breast exams once every 24 months
Cardiac rehabilitation services	No.	20% Coinsurance	Medicare covers 2 sessions per day (1 hour each), up to 36 sessions
Cardiovascular disease risk reduction visit		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Cardiovascular disease testing		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.

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Cervical and vaginal cancer screening (Pap tests, pelvic exams)		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. • All women: Every 24 months • High risk of cervical cancer or abnormal pap: Every 12 months
Chiropractic services	Yes, for more than 12 visits	20% Coinsurance	Only manual manipulation to correct subluxation. Massage therapy not covered. Per CMS x-rays billed by a chiropractor are not covered. X-rays are covered if performed by Radiologist. Also See New Non-Medicare Chiropractor Supplemental Benefit under: Alternative Medicine: Acupuncture and Naturopathy and Non-Medicare Chiropractor
Clinical Trials	Yes		
Colorectal cancer screening (Colonoscopy, Sigmoidoscopy)		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply. For age 50 and older: • Sigmoidoscopy every 48 months • Fecal occult blood test, every 12 months For at high risk of colon cancer: • Screening colonoscopy every 24 months Not at high risk of colon cancer: • Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening sigmoidoscopy.

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Cosmetic surgery or procedures (Partial Exclusion)	Yes		Only covered because of an accidental injury or to improve a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial Care (Exclusion)	Not Covered	Not Covered	Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps with activities of daily living, such as bathing or dressing. Custodial care is not *medically necessary.*
Deductible - Part B Services		$203.00 total for year	Outpatient services before Medicaid processes the claim.
Dental Services (Medical Services, Not Routine Dental)	Refer to prior authorization list.	See specific medical services for related copays and coinsurance.	Covered services limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.
Dental Services (Supplemental preventive and comprehensive)	Referral not required for supplemental dental services.	0% Coinsurance for preventive and comprehensive dental services.	$3000.00 Comprehensive dental total benefit maximum. amount. There is no limit to preventive care(exams, cleanings). Preventive care is not included in the $3000.00 limit. Medicare covered (medical) dental related services do not apply to the supplemental dental benefit.

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Depression screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Diabetes screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Diabetes self-management training, diabetic services and diabetes supplies (DME)	Prior auth required when glucose monitor, shoes or inserts (orthotics) greater than $500.00	20% Coinsurance	• Blood glucose monitor • Blood glucose strips • Lancet devices • Glucose-control solutions for checking accuracy of strips and monitor • One pair of diabetic shoes per calendar year • 2 sets of shoe inserts (orthotics) covered per calendar year (diabetic)
Durable medical equipment (DME) and related supplies	Some DME requires prior authorization, check procedure codes for details. All DME with a purchase price greater than $500.00 allowed, requires prior authorization.	*20% Coinsurance	Covered, provided Medicare criteria are met. DME includes, wheelchairs, hospital beds, walkers,oxygen. *When primary diagnosis is COPD the coinsurance is zero.
Emergency care (Emergency Room, ER)		20% coinsurance (facility) up to $90.00 maximum copay for ER visit	This is the coinsurance before Fee-for Service processes the claim. The member pays nothing. Coinsurance waived if admitted as inpatient within the same hospital within 3 days.
Emergency care (ER Physician Service)		20% coinsurance	

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Emergency care: Supplemental World-wide - Facility and Professional Services		20% Coinsurance	$25,000.00 Maximum - ER coinsurance is not waived if admitted to hospital.
Enteral Feedings, Tube Feedings (Infusion Therapy, DME)	Yes	20% Coinsurance	
Enteral Formula (Infusion Therapy, DME)	Yes	20% Coinsurance	
Eye exam - Medicare Covered (medical vision disease)		20% Coinsurance	Exams to diagnose diseases and conditions of the eye covered by Medicare.If provider is participating then physician's order is required. If provider is not participating then plan approved referral is required.
Eye exam - Routine Vision (VSP Advantage)		In network $0 copay	Through VSP - One WellVision exam every year. Members must use the VSP Choice Network for in-network benefits. Out of network - $47.00 is allowed toward the cost of the exam.
Eye Wear - Medicare covered (Post Cataract Vision Surgery)		20% Coinsurance	Covered, provided Medicare criteria are met. One pair of eyeglasses or contact lenses includes insertion of an intraocular lens after each surgery.

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Eye Wear - Supplemental Benefit - Prescription Contacts, frames,vision lenses,upgrades, extra pair of glasses (VSP Advantage)		• In network - Lenses (for glasses) - $0 copay • In network - Frame or contact lenses - $400.00 every two years allowed toward cost.	Through VSP - every 2 years. Members must use the VSP Choice Network for in-network benefits. • Out of network - Lenses - (for glasses) - Amount allowed toward costs: Single vision $30 Lined bifocal or Progressive $50 Lined trifocal $60 Lenticular $75 • Out of network - Frame or contact lenses -Amount allowed toward costs: Frame $45 Contact lenses (in lieu of lenses and frame) $85
Eye and Vision Services Not Covered by Medicare (Exclusions)		Not Covered. See Additional Information	• Radial keratotomy not covered • LASIK surgery not covered • Vision Therapy not covered • Low Vision Aids not covered
Genetic Testing Not Related to Pregnancy	Yes	20% Coinsurance	
Hearing exam (Medicare covered-to diagnose and treat specific diseases and conditions.)		20% Coinsurance	Covered, provided Medicare criteria are met. Routine hearing exams, hearing aids, and hearing aid fittings are not covered by Medicare.

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Benefit or Service	Prior Authorization	Member Cost Share Same as Original Medicare for Medicare covered services. These services may also be subject to annual Part A & B deductible in addition to copays and coinsurance. Submit cost shares to Medicaid.	Additional Information
Hearing exam (Routine) Supplemental benefit, not covered by Medicare		$0 copay	Routine Hearing Exam must be performed by audiologist. 1 per year.
Hearing aid fittings and evaluation Supplemental benefit, not covered by Medicare		$0 copay	1 per year.
Hearing aids and hearing aid supplies Supplemental benefit, not covered by Medicare		Cost share is anything over $1700.00 benefit maximum.	$1700.00 dollar benefit maximum every calendar year. This benefit includes hearing aid related supplies and repairs and applies to the $1700.00 maximum.
HIV screening		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Home health, Home Health Agency care	Required for Home Health Services. Services related to the Home Health care may also require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.	$0 coinsurance	20% coinsurance for durable medical equipment (DME) still applies when related to Home Health services.
Homemaker Services (Exclusion)	Not Covered	Not Covered	Services include basic household assistance, light housekeeping or light meal preparation.

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Hospice care (inpatient and home)	No.		You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan.
Hyperbaric oxygen treatment	Yes	20% Coinsurance	
Immunizations		$0 Coinsurance	Covered: - pneumonia - influenza (flu shot) - Hepatitis B *Shingles vaccine (Zostavax) is covered under pharmacy - Part D Benefit*
Infusion Therapy, Home Infusion Therapy	Not Required for Infusion Therapy Services. Services related to the Infusion Therapy care may require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.	20% coinsurance	Not Required for Infusion Therapy Services. Services related to the Infusion Therapy care may require prior authorization, for example medication, enteral nutrition. Review Prior Authorization list for related services.
Injections, Injectable drugs (Prescription drugs Medicare Part B medical benefits)	See Prior Authorization (PA) List Note: All Unclassified biologics (J3590) require a prior authorization.	20% Coinsurance	Covered, provided Medicare criteria are met. Includes chemotherapy related drugs, drugs related to home dialysis, B12, etc.

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Inpatient hospital Blood (including inpatient skilled nursing facility/SNF)		No Blood Deductible 0% coinsurance	Coverage begins with the first pint of blood needed. Includes storage and administration. The patient is responsible for any other applicable coinsurance amounts.
Outpatient Blood		No Blood Deductible 0% coinsurance	Coverage begins with the fourth pint of blood needed. Coverage of storage and administration begins with the first pint of blood needed. The patient is responsible for any other applicable coinsurance amounts.
Inpatient hospital (acute) care	Yes	Deduct: $1484.00 Days: 01-60 - $ 00.00 61-90 - $371.00 91-over -$742.00	Inpatient Facility deductible and copays are before Fee-for Service processes the claim. Deductible and copays apply per benefit period. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Plan covers 90 days for an inpatient stay. 91 and over are the 60 additional lifetime reserve days available if not already used.
Inpatient Professional Services		20% Coinsurance	

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Inpatient Hospital (facility) mental health, psychiatric, psychiatrist) care	Yes	Deduct: $1484.00 Days: 01-60 - $ 00.00 61-90 - $371.00 91-over -$742.00	Inpatient Facility deductible and copays are before Fee-for Service processes the claim. Deductible and copays apply per benefit period.Plan covers 90 days for a psychiatric facility inpatient stay. 91 and over are the 60 additional lifetime reserve days available if not already used. 190-day lifetime limitation in a psychiatric facility. The 190-day lifetime limit does not apply to inpatient psychiatric services furnished in a general hospital. All admissions, planned and urgent, require notification within 24 hrs. or next business day.
Inpatient Facility rehabilitation services (physical, speech, occupational therapies)	Yes	Deduct: $1484.00 Days: 01-60 - $ 00.00 61-90 - $371.00 91-over -$742.00	Inpatient Facility deductible and copays are before Fee-for Service processes the claim. Deductible and copays apply per benefit period. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Plan covers 90 days for an inpatient stay. 91 and over are the 60 additional lifetime reserve days available if not already used.
Inpatient services covered during a non-covered inpatient stay		20% coinsurance	Covered, provided Medicare criteria are met.
Inpatient Facility substance abuse	Yes	Deduct: $1484.00 Days: 01-60 - $ 00.00 61-90 - $371.00 91-over -$742.00	Inpatient Facility deductible and copays are before Fee-for Service processes the claim. Deductible and copays apply per benefit period. All admissions, planned and urgent, require notification within 24 hrs. or next business day. Plan covers 90 days for an inpatient stay. 91 and over are the 60 additional lifetime reserve days available if not already used.

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Kidney disease and conditions (Hemodialysis, Dialysis, End Stage Renal Disease/ESRD)	NO. Effective 01/01/2016 Notification is required.	20% coinsurance	
Kidney disease education (on dialysis)	No.		Medicare covers 6 sessions of kidney disease education per lifetime per Medicare.
Mastectomy related bras and supplies (DME)	If over $500.00	20% cost share	
Meal, Meals Benefit (Supplemental)		0% cost share	Meals can be delivered to the home upon discharge from a hospital or skilled nursing facility. 2 meals per day up to 14 days after discharge, up to 6 occurrences per year. Meals to dine with members that are inpatient are not covered.
Medical nutrition therapy education	No	0% cost share	Education for people with diabetes, kidney disease (patient not on dialysis) post kidney transplant. 3 hrs. for first year. 2 hrs. each year after the first year.
Nurse Advice Line		0% cost share	24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006
Obesity screening and obesity (counseling) therapy		0% cost share	Covered, provided Medicare criteria are met, e.g., body mass index (BMI) of 30 or more, etc.
Organ (Living) Donation (Transplant)	Yes	20% coinsurance	All admissions, planned and urgent, require notification within 24 hrs. or next business day.

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Orthotics (Supportive Devices for feet)	Only covered for diabetic foot disease. Prior auth required for orthotics (shoe inserts) greater than $500.00.	$0 cost share	• 2 sets of shoe inserts (orthotics) covered per calendar year only for diabetic foot disease.
Outpatient diagnostic tests and therapeutic services (lab, radiology, x-ray)	Some require prior authorization. Check PA List and Procedure Codes for more details.	0% Medicare covered lab 20% Other diagnostic procedures	
Outpatient hospital services, includes observation	See Prior Authorization (PA) List	20% coinsurance	
Outpatient mental health (not psychiatrist)		20% Coinsurance	Copay the same for group therapy. Must be Medicare eligible provider. Per CMS, some 'counselors' are not eligible to perform services for Medicare and Medicare Advantage members.
Outpatient psychiatrist care		20% coinsurance	Coinsurance the same for group therapy.
Outpatient rehabilitation services (physical, speech, occupational therapy)	Prior authorization required after initial 12 visits.	20% coinsurance	12 visits allowed for each type of therapy. 12 PT, 12 OT and 12 ST. Prior Authorization is required for additional visits after the initial 12 visits. Evaluation and reevaluation is separate from the 12 visits.

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Outpatient substance abuse services	Yes	20% coinsurance	Opioid Treatment Services, to allow codes G2067 through G2080, the provider must be certified with SAMSAH and enrolled with Medicare.
Outpatient surgery, ambulatory surgical centers (ASC)	See Prior Authorization (PA) List	20% coinsurance	
Over the Counter (OTC) medication/pharmacy	Not Covered by Original Medicare, see OVER-THE - COUNTER (OTC) MAIL ORDER for Supplemental Benefit		
Partial hospitalization service (intensive outpatient mental health services)		20% coinsurance	Must be Medicare eligible provider. Per CMS, some 'counselors' are not eligible to perform services for Medicare and Medicare Advantage members.
Physician/Practitioner/PCP services, including doctor's office visits		0% coinsurance	
Physical Exam,See Welcome to Medicare Preventive Visit and Annual Wellness Visit		See Welcome to Medicare Preventive Visit and Annual Wellness Visit	See Welcome to Medicare Preventive Visit and Annual Wellness Visit
Podiatry Services (Foot Care) When Not Covered by Medicare (Supplemental Benefit)		0% coinsurance	4 visits each year - Not limited to Medicare covered diagnosis codes. NEW, when the primary care is Diabetes an additional 4 visits each year for a total of 8 Non-Medicare covered visits.

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Podiatry Services (Foot Care) Medical Medicare Covered		*20% coinsurance	*When the primary care is Diabetes the office visit (E & M service) coinsurance is zero. Medicare covered podiatry limited to Medicare covered diagnosis codes.
Prescription drugs Medicare Part B medical benefits (injectable drugs, injections)	See Prior Authorization (PA) List	20% coinsurance	Includes chemotherapy related drugs, drugs related to home dialysis, etc.
Prescription drugs Medicare Part D pharmacy benefit (drug list, formulary)		Pharmacy Part D is covered.	Over the counter (OTC) not covered
Primary Care Physician (PCP)		20% coinsurance	
Prostate cancer screening exams (PSA)		$0 copay	"For planned preventive services that become diagnostic during the screening, cost sharing may apply. For men over age 50: • Every 12 months: Digital rectal exam • Every 12 months PSA test
Prosthetic devices and related supplies (DME)	See Prior Authorization (PA) List	20% coinsurance	
Pulmonary rehabilitation services		20% coinsurance	Limited to a maximum of 2 1-hour sessions per day for up to 36 sessions, with the option for an additional 36 sessions if medically necessary.

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Screening and counseling to reduce alcohol misuse		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs		$0 copay	For planned preventive services that become diagnostic during the screening, cost sharing may apply.
Shoes, Diabetic- SEE Diabetes self-management training, diabetic services and diabetes supplies (DME)			
Shoes, Orthopedic/Prosthetic with Braces (DME)	Yes, greater than $500.00	20% coinsurance	Limited coverage. Prosthetic/Orthopedic Shoes that are part of a leg brace are covered and included in the cost of the leg brace.
Skilled nursing inpatient facility (SNF) care (Part A)	Yes	Days: 01-20 - $ 00.00 21-100 - $185.50 +100 - All costs	Three day acute inpatient hospital days are not required prior to SNF admission. SNF copays are applied each benefit period. Custodial (not medically necessary) care is not covered. All admissions, planned and urgent, require notification within 24 hrs. or next business day.
Skilled nursing facility (SNF) inpatient care (Part B)		20% coinsurance	Part B (outpatient) coinsurance and benefit limits apply.
Skilled nursing facility (SNF) Blood		No blood deductible 0% coinsurance	

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Sleep Studies	No.	20% coinsurance	
Smoking and tobacco use cessation		0% Coinsurance	• No disease - 8 sessions per calendar year • Disease related - 8 sessions per calendar year
Sterilization Reversal (Exclusion)	Not Covered	Not Covered	Reversal of sterilization procedures and non-prescription contraceptive supplies.
Specialist Physician Care/Services (does not apply to psychiatrists, mental health, lab or radiology)		20% coinsurance	
Telemedicine, Telehealth (Virtual care)		20% coinsurance	Covered. Must meet Original Medicare criteria.
Telemedicine, Telehealth (Virtual care) - Supplemental		Member cost share same as in-person cost shares for: Urgently Needed Services; Primary Care Physician Services; Physician Specialist Services; Individual and Group Sessions for Mental Health Specialty Services; Individual and Group Sessions for Psychiatric Services; Individual and Group Sessions for Outpatient Substance Abuse.	Medicare criteria does not have to be met.

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Transplant Evaluation/Work-Up	Yes	0% coinsurance (lab)	
Transplant	Yes except for corneal transplants	20% coinsurance	Corneal transplant does not require prior authorization (PA), other transplants do require PA. All admissions, planned and urgent, require notification within 24 hrs. or next business day.
Transportation: SEE AMBULANCE or TRANSPORTATION (NON-EMERGENT) SUPPLEMENTAL BENEFIT	Transportation: SEE AMBULANCE or TRANSPORTATION (NON-EMERGENT) SUPPLEMENTAL BENEFIT	Transportation: SEE AMBULANCE or TRANSPORTATION (NON-EMERGENT) SUPPLEMENTAL BENEFIT	Transportation: SEE AMBULANCE or TRANSPORTATION (NON-EMERGENT) SUPPLEMENTAL BENEFIT
Unlisted Codes with Charge Greater Than $250.00	Yes		Unlisted codes is the actual, AMA description of the service. Medical necessity documentation and pricing must be submitted with the request. Example: 43499, Unlisted procedure, esophagus.
Urgent (Urgently) needed care		20% coinsurance up to $65.00 maximum.	This coinsurance is before Medicaid processes the claim. The member pays nothing.
Vision Care SEE EYE EXAM AND EYE WEAR	See Eye Exam and Eye Wear	See Eye Exam and Eye Wear	See Eye Exam and Eye Wear

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Welcome to Medicare Preventive Visit (Initial Preventive Physical Exam/IPPE or Annual Wellness Visit/AWV)		$0 copay	1 visit lifetime max within 12 months of Part B effective date. For planned preventive services that become diagnostic during the screening, cost sharing may apply. If greater than 12 months from the effective date and did not receive a Welcome Exam see Annual Physical Exam
Wig (DME)	Yes if +$500.00	20% coinsurance	Must be medically necessary and meet criteria to covered by Medicare.
Lung Cancer Screening		$0 copay	Limited to ages 55 through 77, once per year.