COMMUNITY HEALTH PLAN of Washington™ | MEDICARE ADVANTAGE
The power of community

| 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 for Original Medicare covered services. | Additional Information |
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| 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.<br>• Up to 12 visits in 90 days.<br>• 8 additional sessions will be covered if improvement is demonstrated from the initial 12 visits<br>• No more than 20 visits in a calendar year. |
| Alternative Medicine: acupuncture, chiropractic, massage therapy, naturopathy<br>* New Name for Alternative Medicine, 2023 Health and Wellbeing | | 0% coinsurance | 25 visit limit which is a combination of visits from Acupuncturists, Massage Therapists, Naturopaths and Chiropractor visits not covered by Medicare. X-rays performed by a Chiropractor are not covered. (Now called Health and Wellbeing) |
| AIR Ambulance (Non-emergency) | | 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.<br>ALSO SEE TRANSPORTATION SUPPLEMENTAL (NON-EMERGENT) BENEFIT. |
| Anesthesiologist (Anesthesia) | | $0 copay | For professional services. |
| 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 |


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| 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.<br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram every 12 months for age 40 and older<br>• Clinical breast exams once every 24 months |
| Cardiac rehabilitation services | No. | 20% Coinsurance | |
| 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. |
| 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.<br>• All women: Every 24 months<br>• High risk of cervical cancer or abnormal pap: Every 12 months |

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| Chiropractic services (Original Medicare covered) | 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 supplemental benefit Health and Wellbeing. |
| Clinical Trials | Yes | | |
| Colorectal cancer screening (Colonoscopy, Sigmoidoscopy) | | $0 copay | For planned preventive services that become diagnostic during the screening, cost sharing may apply.<br>For age 50 and older:<br>• Sigmoidoscopy every 48 months<br>• Fecal occult blood test, every 12 months<br>For at high risk of colon cancer:<br>• Screening colonoscopy every 24 months<br>Not at high risk of colon cancer:<br>• Screening colonoscopy every 10 years (120 months) but not within 48 months (2 years) of a screening sigmoidoscopy. |
| 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 for Facility, Medicare Part A (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.* |


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| Custodial Care for Professional, Medicare Part B | | 20% Coinsurance | • If Medicare Part A for a hospital or skilled nursing facility (SNF) stay is not covered because it's considered custodial care, individual Medicare Part B services that are reasonable and medically necessary to treat the patient's illness or injury, like periodic patient visits by a physician are covered.<br>• Custodial care doesn't exclude payment for Part B claims for medically necessary ancillary services.<br>• Hospice related care is covered by Original Medicare not CHPW |
| Deductible - Part B Services | | $257.00 | Outpatient services before Medicaid processes the claim. |
| Dental Services (Medicare Services, Not Routine Dental) | Refer to prior authorization list. | See specific medical services for related copays and coinsurance. Submit claims to CHPW. | 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. | Must see Delta Dental In-Network Provider<br>0% Coinsurance for preventive and comprehensive dental services.<br>Submit claims to Delta Dental | Must see Delta Dental In-Network Provider. $5000.00 Comprehensive and Preventive dental total benefit maximum. amount. 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<br>• Blood glucose strips<br>• Lancet devices<br>• Glucose-control solutions for checking accuracy of strips and monitor<br>• One pair of diabetic shoes per calendar year<br>• 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 or more than $200.00 per month for rental, 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 for oxygen is 20%. |
| Emergency care (Emergency Room, ER) | | 20% coinsurance (facility) up to $100.00 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 | |
| Emergency care: Supplemental World-wide - Facility and Professional Services | | 20% Coinsurance | $25,000.00 Maximum - ER coinsurance is not waived if admitted to hospital. |


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| 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. Submit Claims to CHPW. |
| 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 - $45.00 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. Submit claims to CHPW. |


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| Eye Wear - Supplemental Benefit - Prescription Contacts, frames,vision lenses,upgrades, (VSP Choice) | | •Available every year.<br>• In VSP Choice network<br>•Frame or contact lenses instead of glasses - $500.00 every year allowed toward cost. Any frame over the allowance is member responsibility.<br>• Lenses (for glasses) - $0 copay for the following lenses:<br>o Single Vision<br>o Lined bifocal<br>o Lined trifocal<br>o Lenticular<br>• Lenses and lens enhancements not included in the $0 copay, are the member's responsibility. Average 30% savings on lens and enhancements. | Members must use the VSP Choice Network for in-network benefits. Out of network - Any amount over the out of network annual allowance is patient responsibility. Submit claims to VSP.<br>•Frame, $70 allowed toward costs.<br>•Contact lenses (in lieu of lenses and frame) $105.<br>•Single vision Lenses - up to $30<br>•Lined bifocal - up to $50<br>•Lined trifocal - up to $65<br>•Lenticular - up to $100<br>•Progressive - up to $50 |
| Eye and Vision Services Not Covered by Medicare (Exclusions) | | Not Covered. See Additional Information | • Radial keratotomy not covered<br>• LASIK surgery not covered<br>• Vision Therapy not covered<br>• Low Vision Aids not covered |
| Genetic Testing Not Related to Pregnancy | Yes | 20% Coinsurance | |


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| 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. |
| Hearing exam (Routine)<br>Supplemental benefit, not covered by Medicare | | $0 copay | Routine Hearing Exam must be performed by audiologist. 1 per year. |
| Hearing aid fittings and evaluation<br>Supplemental benefit, not covered by Medicare | | $0 copay | 1 per year. |
| Hearing aids and hearing aid supplies<br>Supplemental benefit, not covered by Medicare | | Cost share is anything over $2250.00 benefit maximum. | $2250.00 dollar benefit maximum every calendar year. This benefit includes hearing aids, one aid per ear, per year. OTC hearing aids are allowed and subject to limit of one aid, per ear, per year and hearing aid related supplies and hearing aid repairs and applies to the $2250.00 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. |


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| Homemaker Services (Exclusion) | NOT COVERED | NOT COVERED | Services include basic household assistance, light housekeeping or light meal preparation. |
| 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:<br>- pneumonia<br>- influenza (flu shot)<br>- Hepatitis B<br>- COVID-19<br>- Other vaccines if at risk and meet Original Medicare Part B coverage rules<br>*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. |


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| 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. |
| Inpatient hospital Blood (including inpatient skilled nursing facility/SNF) | | No Blood Deductible<br>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<br>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 | Part A Deductible: $1676.00<br>Days copay:<br>01-60 - $ 00.00<br>61-90 - $419.00<br>*91-150 - $838.00<br>*Limit 60 Lifetime Reserve Days<br>151: All costs to member | 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 Psychiatric Hospital (mental health, psychiatric, psychiatrist) care | Yes | Part A Deductible: $1676.00<br>Days copay:<br>01-60 - $ 00.00<br>61-90 - $419.00<br>*91-150 - $838.00<br>*Limit 60 Lifetime Reserve Days<br>151: All costs to member | 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 | Part A Deductible: $1676.00<br>Days copay:<br>01-60 - $ 00.00<br>61-90 - $419.00<br>*91-150 - $838.00<br>*Limit 60 Lifetime Reserve Days<br>151: All costs to member | 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 (SUD) | Yes | Part A Deductible: $1676.00<br>Days copay:<br>01-60 - $ 00.00<br>61-90 - $419.00<br>*91-150 - $838.00<br>*Limit 60 Lifetime Reserve Days<br>151: All costs to member | 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. |
| Orthotics (Supportive Devices for feet) | Only covered for diabetic foot disease.<br><br>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. |


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| 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<br>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 (PT), speech (ST), occupational therapy (OT)) | 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. |
| 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 | |
| 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 | | 20% coinsurance | |


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| 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. |
| 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.<br>For men over age 50:<br>• Every 12 months: Digital rectal exam<br>• Every 12 months PSA test |
| Prosthetic devices and related supplies (DME) | See Prior Authorization (PA) List | 20% coinsurance | |
| Screening and counseling to reduce alcohol misuse | | $0 copay | For planned preventive services that become diagnostic during the screening, cost sharing may apply. |


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| 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 | Copay Days:<br>01-20 - $ 0.00<br>21-100 - $209.50<br>+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<br>0% coinsurance | |
| Sleep Studies | No. | 20% coinsurance | |
| Smoking and tobacco use cessation | | 0% Coinsurance | • Contact Optum at 1-866-784-8454 (1-866-QUIT-4-LIFE).<br>• No disease - 8 sessions per calendar year<br>• Disease related - 8 sessions per calendar year |
| Sterilization Reversal (Exclusion) | Not Covered | Not Covered | Reversal of sterilization procedures and non-prescription contraceptive supplies. |


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| Specialist Physician Care/Services (does not apply to psychiatrists, mental health, lab or radiology) | | 20% coinsurance | |
| Telemedicine, Telehealth (Virtual care) - Medicare | | 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. |
| 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. |
| 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.<br>Example: 43499, Unlisted procedure, esophagus. |


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| Urgent (Urgently) needed care | | 20% coinsurance up to $45.00 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 |
| 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. |


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| FITNESS BENEFIT | | $0 copay | Membership at participating fitness centers or 2 Home Fitness Kits per year:<br>Includes:<br>• Access to Silver& Fit website including The Silver Slate newsletter, healthy aging education program, motivational tips and rewards.<br>• 34 Home Fitness Kits to choose from<br>• Single fitness center access; can be changed once per month.<br>• Customer Service, open Monday through Friday, 5 AM through 6 PM PST<br>• Tele. 1-877-427-4788 |
| OVER-THE - COUNTER (OTC) MAIL ORDER - COMBINED WITH GROCERY CHARGES (Supplemental Benefit) | | | •OTC Limited to $100.00 allowance, per month, less any amount used for groceries, no cash, checks or credit card payment accepted for amounts over $100.00 (per month).<br>OTC Orders are limited to 1 shipment per month (can include multiple items)<br>• OTC Items can be ordered:<br>o on-line - https://shopping.drugsourceinc.com/<br>o by phone at 1-877-603-0402 |
| Nurse Advice Line | | 0% cost share | 24 hour nurse hotline available: 1-866-418-1002 or TTY 1-866-418-1006 |
| Supervised Exercise Therapy (SET) | | 20% coinsurance | Only for members who have symptomatic peripheral artery disease (PAD). No referral is required. The SET provider must meet Medicare requirements.<br>Covered up to 36 sessions over a 12-week period if all of the components of a SET program are met. |


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| Medicare Diabetes Prevention Program (MDPP) | | No Cost Shares | Provider must be enrolled in Medicare as an MDPP supplier to bill for MDPP services.<br>• Therapeutic exercise-training program for PAD.<br>• Conducted in a hospital outpatient setting, or a physician's office<br>• Delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD |
| Transgender Services | | Cost share determined by service, e.g. outpatient hospital copay, specialist visit, etc. | The procedure code must be covered by Original Medicare with an allowed amount on the Medicare fee schedule. The PCLT can be referenced for covered codes and prior authorization requirements: https://forms.chpw.org/pclt. |
| Member Total Out-of-Pocket (MOOP) *before Medicaid reimbursement* | | $9,350.00 | |
| Family on Demand | NOT COVERED | NOT COVERED | |
| Health and Wellbeing | | 0% coinsurance | New: 25 visit limit which is a combination of visits from Acupuncturists, Massage Therapists, Naturopaths and Chiropractor visits not covered by Medicare. X-rays performed by a Chiropractor are not covered. |


| 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 for Original Medicare covered services. | Additional Information |
|---|---|---|---|
| Grocery and other Over the Counter (OTC)products | | Anything over $100.00 per month for combined grocery and OTC charges. | •OTC Limited to $100.00 allowance, per month, less any amount used for groceries, no cash, checks or credit card payment accepted for amounts over $100.00 (per month).<br>OTC Orders are limited to 1 shipment per month (can include multiple items)<br>• OTC Items can be ordered:<br>o on-line - https://shopping.drugsourceinc.com/<br>o by phone at 1-877-603-0402 |
| Pulmonary rehabilitation services | See Prior Authorization List and Procedure Code Look Up Tool. | 20% Coinsurance | Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. |
| TRANSPORTATION (NON-EMERGENT) SUPPLEMENTAL BENEFIT to Plan approved health care locations | N/A | $0 copay | •20 ONE WAY TRIPS. 40 Mile Limitation. PA required for over 40 miles. This benefit is in addition to the Non-Emergency Transportation (NEMT) covered by WA Medicaid.<br>• Transportation provided by Roundtrip, together with Lyft.<br>• Rides available Mon. through Sat. 4 AM to 9 PM PST.<br>• Call to schedule, Mon. through Fri. between 8 AM and 8 PM PST<br>• Tele. 1-833-209-6382 |