Sample Qualified Incentive Pool Provider

Health Benefit

The following is being provided as a reference guide for the QIPPs that do not participate in a health benefit fund for their home health care and/or personal care aides. This is the minimum required benefit.

BENEFIT	AMOUNT OF COVERAGE
Hospital Care	➢ This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility. ➢ Up to 365 days per year ➢ Semi-private room and board ➢ Acute care for Medically Necessary services ➢ Inpatient admissions ➢ Outpatient or ambulatory facilities ➢ Observation care and services ➢ Up to 30 days for inpatient physical rehabilitation.
Hospice Care	➢ Coverage for a combined total of up to 210 days per lifetime in a Medicare-approved hospice program in a hospice center, hospital, skilled nursing facility or at home.
Emergency Room Visits	➢ This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility. ➢ Use of the Emergency Room must be for an emergency and within 72 hours of an accident or sudden and serious illness
Program for Behavioral Health	***Mental Health:*** ➢ Outpatient treatment ➢ Inpatient Care ***Alcohol/Substance Abuse:*** ➢ Medically Necessary services for inpatient detoxification ➢ Up to 30 days within a 12-month period for inpatient rehabilitation ➢ Outpatient treatment
Surgery	➢ Inpatient or outpatient (ambulatory) surgery
Anesthesia	➢ Allowable

Maternity Care	➢ An allowance that includes all prenatal and postnatal visits and delivery charges ➢ Hospital benefit
Medical Services	➢ Treatment in a doctor's office ➢ Immunizations ➢ X-rays and laboratory tests ➢ Dermatology: up to 20 treatments per year ➢ Chiropractic: up to 12 treatments per year ➢ Podiatry: up to 15 treatments per year for routine care ➢ Allergy: up to 20 treatments per year, including diagnostic testing ➢ Outpatient chemotherapy, radiation therapy and hemodialysis ➢ Ambulance Services
Medical Services Requiring Prior Authorization	➢ Home healthcare ➢ Non-emergency ambulance services ➢ Durable medical equipment and appliances ➢ Medical supplies ➢ Specific medications ➢ Home infusion services and supplies ➢ MRI, MRA, PET and CAT scans and certain nuclear cardiology procedures ➢ Ambulatory/outpatient surgery ➢ Hospice care
Vision Care	➢ One eye exam every two years ➢ One pair of glasses or contact lenses every two years
Hearing Aids	➢ Once every three years ➢ Call for referrals to a Participating Provider
Basic Dental Care	➢ Basic and preventive services through Participating Provider network ➢ Initial/periodic oral exams once every 6 months ➢ Bitewing X-rays once every 6 months ➢ Prophylaxis, scaling and fluoride once every 6 months ➢ Dental emergencies ➢ Minor restorative services ➢ Denture adjustments, repairs and relines
Major Dental Care	➢ Major restorative work through Participating Providers ➢ Oral surgery ➢ Crowns, bridges, dentures and periodontal care once every 60-month period
Prescription Drugs	➢ FDA-approved prescription medications

- No deductible when you use generic drugs and preferred drugs where available.
- Co-payments for brand and generic drugs; no deductible when you use generic drugs and preferred drugs where available.
- Use Participating Pharmacies
- Maintenance drug access program for chronic conditions
- Prior authorization needed for certain medications

COBRA

- If you lose your eligibility for health benefits, you may be able to extend your coverage.
- Must notify the benefit coordinator within 60 days of a "qualifying event."
- "Qualifying events" determine length of coverage – either 18 or 29 months.

Workers' Compensation

- For injuries at work or work-related illness
- Must file claim with your employer or you may jeopardize your rights