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*.

[Plans should refer members to other parts of the handbook using the appropriate chapter number, section, and/or page number. For example, "refer to Chapter 9, Section A, page 1." An instruction [plans may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

[Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.]

Table of Contents

[A. Your covered services [*insert if the plan has cost sharing:* and your out-of-pocket costs] 2](#_Toc67377441)

[A1. During public health emergencies 2](#_Toc67377442)

[B. Rules against providers charging you for services 2](#_Toc67377443)

[C. Our plan’s Benefits Chart 2](#_Toc67377444)

[C1. Restricted Recipient Program 4](#_Toc67377445)

[D. The Benefits Chart 7](#_Toc67377446)

[E. Our plan’s visitor or traveler benefits 64](#_Toc67377447)

[F. Benefits covered outside of <plan name> 64](#_Toc67377448)

[F1. Hospice care 64](#_Toc67377449)

[F2. Other Services 65](#_Toc67377450)

[G. Benefits not covered by <plan name>, Medicare, or Medicaid (Medical Assistance) 66](#_Toc67377451)

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

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

Because you get assistance from Medical Assistance (Medicaid), you pay nothing for your covered services as long as you follow the plan’s rules. Refer to Chapter 3 [plans may insert reference, as applicable] for details about the plan’s rules.

If you need help understanding what services are covered, call your [plans may insert: care coordinator and/or Member Services at the number at the bottom of this page]. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

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

## A1. During public health emergencies

[*Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include 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. Plans also include 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 [plans may insert reference, as applicable] or call Member Services at the number at the bottom of this page.

# Our plan’s Benefits Chart

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. [Plans that include an index at the end of the chapter should insert: To find a service in the chart, you can also use the index at the end of the chapter.]

**We will pay for the services listed in the Benefits Chart only when the following rules are met.** You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.

* Your Medicare and Medical Assistance (Medicaid) covered services must be provided according to the rules set by Medicare and Medical Assistance (Medicaid).
* The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means services, supplies, or drugs you need to prevent, diagnose, or treat your 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 care is appropriate for your condition. This includes care related to physical conditions and mental health. It includes the kind and level of services. It includes the number of treatments. It also includes where you get the services and how long they continue. Medically necessary services must:
* be the services, supplies, and prescription drugs that other providers would usually order.
* help you get better or stay as well as you are.
* help stop your condition from getting worse.
* help prevent and find health problems.
* [Insert if applicable: 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 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.]
* [Insert if applicable: You have a primary care provider (PCP) or a care team that is providing and managing your care. [Plans that do 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 [plans may insert reference, as applicable] has more information about getting a referral and explains when you do not need a referral.]
* [Insert if applicable: 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. Covered services that need prior authorization 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 prior authorization for the following services that are not listed in the Benefits Chart: [insert list].]
* [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.]

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

## C1. Restricted Recipient Program

* The Restricted Recipient Program is for members who have misused health services. This includes getting health services that members did not need, using them in a way that costs more than they should, or using them in a way that may be dangerous to a member’s health. <MCO Name> will notify members if they are placed in the Restricted Recipient Program.
* If you are in the Restricted Recipient Program, you must get health services from one designated primary care provider [insert if applicable:in your local trade area], one clinic, one hospital used by the primary care provider, and one pharmacy. <MCO Name> may designate other health care providers. You may also be assigned to a home health agency. You may not be allowed to use the personal care assistance choice or flexible use options or consumer directed services.
* You will be restricted to these designated health care providers for at least 24 months of eligibility for Minnesota Health Care Programs (MHCP). All referrals to specialists must be from your primary care provider, and received by the <MCO Name> Restricted Recipient Program. Restricted recipients may not pay out-of-pocket to use a non-designated provider who is the same provider type as one of their designated providers.
* Placement in the program will stay with you if you change health plans. Placement in the program will also stay with you if you change to MHCP fee-for-service. You will not lose eligibility for MHCP because of placement in the program.
* At the end of the 24 months, your use of health care services will be reviewed. If you still misused health services, you will be placed in the program for an additional 36 months of eligibility.
* You have the right to appeal placement in the Restricted Recipient Program. You must file an appeal within 60 days from the date on the notice from us. You must appeal within 30 days to prevent the restriction from being implemented during your appeal. A member may request a State Appeal (Medicaid Fair Hearing with the state) after receiving our decision that we will enforce the restriction. Refer to Chapter 9, Section 5.4, for more information about your right to appeal.
* The Restricted Recipient Program does not apply to Medicare-covered services. If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid [*insert if applicable*: or benzodiazepine] medications is not safe, we may limit how you can get those medications. Refer to Chapter 5, Section G3, for more information.

[Instructions on completing the Benefits Chart:

* For all preventive care and screening test benefit information, plans that cover a richer benefit do not 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.
* Plans must include any services provided in excess of the Medicare and Medicaid requirements. Preventive services must be identified with the apple icon.
* HMO POS plan types must provide information about which services must be obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.
* Plans should clearly indicate which benefits are subject to prior authorization. (This can be done with asterisks, footnotes, bold type, or italic type. Plans 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.)
* Plans 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.
* Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member’s access to services within the chart.
* Plans 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.
* Plans may delete services that are listed as non-covered if the plan has chosen to provide a service as a supplemental covered benefit.]
* Plans 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, plans enter a blank return before right aligning and inserting at the bottom of the first part of the description:**This benefit is continued on the next page.**At the top of the next page where the benefit description continues, plans enter the benefit name again followed by **(continued)**.Plans may refer to**Dental services** and other examples later in this chart as examples. Plans should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]

| Services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Apple icon indicates preventive services. | 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.  We may cover additional screenings if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Acupuncture  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 for chronic low back pain each year.  Acupuncture treatments for chronic low back pain must be stopped if you don’t get better or if you get worse.  In addition, the plan will pay for up to 20 units of acupuncture services per calendar year without authorization for the following:   * Acute and chronic pain * Depression * Anxiety * Schizophrenia * Post-traumatic stress syndrome * Insomnia * Smoking cessation * Restless legs syndrome * Menstrual disorders * Xerostomia (dry mouth) associated with the following: * Sjogren’s syndrome * radiation therapy * Nausea and vomiting associated with the following: * postoperative procedures * pregnancy * cancer care   [List any additional benefits offered.] | $0  [*List copays for additional benefits.*] |
| Apple icon indicates preventive services. | [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Alcohol misuse screening and counseling  The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting (refer to the “Substance use disorder services” section of this chart for additional covered benefits [plans may insert reference, as applicable]).  [List any additional benefits offered.] | $0 |
|  | Ambulance services  Covered ambulance services include air (airplane or helicopter), water, and ground 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 indicates preventive services. | Annual wellness visit  If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months.  **Note**: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. | $0 |
| Apple icon indicates preventive services. | 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 pay for the services once every 24 months or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Breast cancer screening (mammograms)  The plan will pay for the following services:   * One screening mammogram every 12 months * Clinical breast exams once every 24 months   We may cover additional services if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | 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 doctor’s [insert as appropriate: referral **or** order].  The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:   * discuss aspirin use, * check your blood pressure, **or** * give you tips to make sure you are eating well.   We may cover additional visits if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease testing  The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.  We may cover additional tests if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Care coordination  The plan pays for care coordination services, including the following:   * Assisting you in arranging for, getting, and coordinating assessments, tests, and health and long-term care supports and services * Working with you to develop and update your care plan * Supporting you and communicating with a variety of agencies and persons * Coordinating other services as outlined in your care plan   [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | Cervical and vaginal cancer screening  The plan will pay for the following services:   * For all women: Pap tests and pelvic exams once every 24 months * For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months * For women who have had an abnormal Pap test: one Pap test every 12 months   We may cover additional services if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Chiropractic services  The plan will pay for the following services:   * One evaluation or exam per year * Manual manipulation (adjustment) of the spine to treat subluxation of the spine – up to 24 visits per calendar year, limited to six per month. Visits exceeding 24 per calendar year or six per month may require a service authorization. * Acupuncture for pain and other specific conditions within the scope of practice by chiropractors with acupuncture training or credentialing * X-rays when needed to support a diagnosis of subluxation of the spine   [List any plan-covered additional benefits offered. Also list any restrictions, such as the maximum number of visits.]  **Note:** Our plan does not cover other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor. | [List copays.]  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Colorectal cancer screening  The plan will pay for the following services:   * Flexible sigmoidoscopy (or screening barium enema) every 48 months * Fecal occult blood test, every 12 months * Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months * DNA based colorectal screening every 3 years   For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months.  **This benefit is continued on the next page** | $0  [List copays for additional benefits.] |
|  | Colorectal cancer screening (continued)  For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).  We may cover additional screenings if medically necessary.  [List any additional benefits offered.] |  |
|  | [Plans should include this row if applicable. Add the apple icon if listing only preventive services.]  Dental services  The plan will pay for the following services:  Diagnostic services including:   * Comprehensive exam once every five years (cannot be performed on same date as a periodic or limited evaluation) * Periodic exam once per calendar year (cannot be performed on same date as a limited or comprehensive evaluation) * Limited (problem-focused) exams once per day (cannot be performed on same date as a periodic or comprehensive oral evaluation or prophylaxis; documentation must include notation of the specific oral health problem or complaint) * Teledentistry for diagnostic services limited to three telemedicine services per member per calendar week * X-rays, limited to: * bitewing once per calendar year * single x-rays for diagnosis of problems * panoramic x-rays once every five years and as medically necessary for diagnosis and follow-up of oral and maxillofacial conditions and trauma; once every two years in limited situations; or with a scheduled outpatient facility or freestanding Ambulatory Surgery Center (ASC) as part of an outpatient dental surgery * full mouth x-rays once every five years only when provided in an outpatient hospital or freestanding ASC as part of an outpatient dental surgery   **This benefit is continued on the next page** | [List copays.] |
|  | Dental services (continued)  Preventive services including:   * Cleaning up to four times per year if medically necessary * Fluoride varnish once per calendar year * Caries medicament application once per tooth per 6 months   Restorative services including:   * Fillings * Sedative fillings for relief of pain * Endodontics (root canals) on anterior teeth and premolars only and once per tooth per lifetime; retreatment is not covered   Periodontics including:   * Gross removal of plaque and tartar (full mouth debridement) once every five years * Scaling and root planing once every two years only when provided in an outpatient hospital or freestanding ASC as part of an outpatient dental surgery * [*Insert if applicable:* Scaling and root planing may also be covered in a clinic setting under certain circumstances. *Also* *include a list of circumstances when adding this bullet.*]   Prosthodontics including:   * Removable prostheses (dentures and partials) once every six years per dental arch [*Insert if applicable:* Partials always require a <service/prior> authorization.] * Relines, repairs, and rebases of removable prostheses (dentures and partials) * Replacement of prostheses that are lost, stolen, or damaged beyond repair under certain circumstances * Replacement of partial prostheses if the existing partial prosthesis cannot be altered to meet dental needs   **This benefit is continued on the next page** |  |
|  | Dental services (continued)  Oral surgery (limited to extractions, biopsies and incision and drainage of abscesses)  Additional general services including:   * Treatment for pain once per day * General anesthesia when provided in an outpatient hospital or freestanding ASC as part of an outpatient dental surgery [*Insert if applicable*: General anesthesia may be covered in a clinic setting under certain circumstances*. Also include a list of circumstances when adding applicable language to this bullet.*] * Extended care facility/house call in certain institutional settings. These include: nursing facilities, skilled nursing facilities, boarding care homes, Institutes for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD), hospices, Minnesota Extended Treatment Options (METO), and swing beds (a nursing facility bed in a hospital) * Behavioral management when necessary to ensure that a covered dental service is correctly and safely performed * Oral or intravenous (IV) sedation only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center   [List any plan-covered additional benefits offered, such as routine dental care, dental X-rays, and cleanings.]  If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance (Medicaid). [*Insert if applicable*: Additional dental benefits offered by <plan name> are only available if you use a dental provider in <plan name>’s provider network.]  If you are new to our plan and have already started a dental service treatment plan, please contact us for coordination of care. |  |
| Apple icon indicates preventive services. | Depression screening  The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.  We may cover additional screenings if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Diabetes screening  The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:   * High blood pressure (hypertension) * History of abnormal cholesterol and triglyceride levels (dyslipidemia) * Obesity * History of high blood sugar (glucose)   Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months  We may cover additional screenings if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | 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.   This benefit is continued on the next page | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Diabetic self-management training, services, and supplies (continued)  [Plans that limit the diabetic supply brands and manufacturers that they will cover, insert: We limit the brands and makers of diabetic supplies we will pay for.]  [Plans insert one of the following:  To get the list that tells you the brands and makers of diabetic supplies that we will pay for, contact Member Services at the number at the bottom of this page. The most recent list of brands, makers, and suppliers is also available on our website at <URL>.  **or**  The supplies listed below are covered for <plan name> members without prior authorization:   * <supply name> * <supply name> * <supply name>   You can also find covered diabetic testing supplies in the List of Covered Drugs at <URL>.]  [List any additional benefits offered.] |  |
|  | [Plans that cover durable medical equipment as a Medicaid benefit should 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 [plans may insert reference, as applicable] of this handbook.)  The following items are covered:   * Wheelchairs * Crutches * Walkers * Powered mattress systems * Hospital beds ordered by a provider for use in the home * IV infusion pumps * Speech generating devices * Oxygen equipment and supplies * Nebulizers   We cover additional items, including:   * repairs of medical equipment * batteries for medical equipment * medical supplies you need to take care of your illness, injury or disability * incontinence products * nutritional/enteral products when specific conditions are met * family planning supplies (refer to the “Family planning services” section of this chart for more information) * augmentative communication devices, including electronic tablets   **This benefit is continued on the next page** | [List copays.] |
|  | Durable medical equipment (DME) and related supplies (continued)  For diabetic supplies refer to the “Diabetic self-management training, services, and supplies” section in this benefit chart.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Medical Assistance (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.]  [Plans that limit the DME brands and manufacturers that you will cover, insert: 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>.  Generally, <plan name> covers any DME covered by Medicare and Medical Assistance (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 doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)  If you (or your doctor) do not agree with the plan’s coverage decision, you or your doctor may file an appeal. You can also file an appeal if you do not agree with your doctor’s decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9 [plans may insert reference, as applicable].)] |  |
|  | Elderly Waiver Services (Home and Community-Based Services)  The plan will pay for the following services for individuals eligible to get Elderly Waiver (EW) services:   * Adult Day Services (ADS) and ADS Bath: Licensed program that delivers a set of health, social and nutritional services. ADS Bath is available. * Adult Foster Care: Licensed, adult appropriate, sheltered living arrangement in a family-like setting. * Case Management: Management of your health and long-term care services among different health and social service workers. * Chore Services: Heavy household services needed to keep your home clean and safe. * Companion Services: Non-medical care, supervision and socialization. * Consumer Directed Community Support Services: Services that you manage yourself within a set budget. * Customized Living/24 Hour Customized Living: A group of individualized services provided in an assisted living setting. * Environmental Accessibility Adaptations: Physical changes to your home and vehicle needed to assure health and safety and enable you to be more independent. * Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance (Medicaid) limit. * Extended State Plan Home Care Nursing: This includes home care nursing services that are over the Medical Assistance (Medicaid) limit. * Extended State Plan Personal Care Assistance Services: Help with personal care and activities of daily living over the Medical Assistance (Medicaid) limit.   **This benefit is continued on the next page** | $0 |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)   * Family and Caregiver Training and Education: Training for unpaid caregivers. This includes coaching and counseling – individualized support for caregivers. * Family Memory Care: Coaching counseling service for caregivers living with a family member or friend with dementia. This also includes assessment. * Home Delivered Meals: Meals delivered to your home. * Homemaker Services: General household activities to keep up the home. These range from general household cleaning to incidental assistance with home management and/or activities of daily living. * Individual Community Living Support Services: A bundled service to offer assistance and support to remain in your own home. * Respite Care: Short-term service when you cannot care for yourself, and your unpaid caregiver needs relief. * Specialized Medical Supplies and Equipment: Supplies and equipment that are over the Medical Assistance limit or coverage. This includes the Personal Emergency Response System (PERS). * Transitional Supports Services: One-time costs related to setting up a household when a person leaves a nursing home and moves to the community. * Transportation: Enables you to gain access to activities and services in the community.   You must have a MnCHOICES assessment, formerly called a Long-Term Care Consultation (LTCC), done and be found to be nursing home certifiable to get these Elderly Waiver (EW) services. You can ask to have this assessment in your home, apartment, or facility where you live.  Your MSHO [insert: care coordinator **or** case manager] will meet with you and your family to talk about your care needs within 20 days if you call to ask for a visit.  **This benefit is continued on the next page** |  |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)  Your MSHO [insert: care coordinator **or** case manager] will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.  You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our plan’s network.  After the visit, your MSHO [insert: care coordinator **or** case manager] will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or care plan you helped put together. Your MSHO [insert: care coordinator **or** case manager] will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services.  People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs, or Fond du Lac Reservations may be able to choose to get their EW services through the Tribal health or human services division or through our plan. Contact the tribal nation or our plan if you have questions.  If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and coordinate with your MSHO [insert: care coordinator **or** case manager].  If you need transition planning and coordination services to help you move to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW. |  |
|  | 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** * serious harm to bodily functions; **or** * serious dysfunction of any bodily organ or part   This coverage is only available within the U.S. and its territories.  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plans should insert information as needed to accurately describe emergency care benefits:(for example, 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.)]. | $0 |
|  | [Plans should modify this as necessary.]  Family planning services  The law lets you choose any provider to get certain family planning services from. These are called open access services. This means any doctor, 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 with prescription (for example, birth control pills) * Family planning supplies with prescription (for example, condoms) * Counseling and diagnosis of infertility, including related services * Counseling and testing for sexually transmitted diseases (STDs) * Counseling and testing for HIV/AIDS and other HIV-related conditions * Treatment for sexually transmitted diseases (STDs) * 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   **This benefit is continued on the next page** | [List copays.] |
|  | Family planning services (continued)  The plan will also pay for some other family planning services. However, you must refer to a provider in the plan’s network for the following services:   * Treatment for medical conditions of infertility * Treatment for AIDS and other HIV-related conditions * Genetic testing   **Note:** Our plan does not cover artificial ways to become pregnant (artificial insemination, including in vitro fertilization and related services; fertility drugs and related services), reversal of voluntary sterilization, and sterilization of someone under conservatorship or guardianship. |  |
| Apple icon indicates preventive services. | [If this benefit is not applicable, plans 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.] | [List copays.] |
|  | Health services  The plan will pay for the following services:   * Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist * Behavioral Health Home: coordination of behavioral and physical health service * Clinical trial coverage   + Routine care that is provided as part of the protocol treatment of a clinical trial; is usual, customary, and appropriate to your condition; and would typically be provided outside of a clinical trial.   + This includes services and items needed for the treatment of effects and complications of the protocol treatment.   + For more information, please refer to Chapter 3 [*plans may insert reference, as applicable*]. * Community health worker care coordination and patient education services * Community Medical Emergency Technician (CMET) services * Post-hospital/post-nursing home discharge visits ordered by your primary care provider * Safety evaluation visits ordered by your primary care provider   **This benefit is continued on the next page** | $0 |
|  | Health services (continued)   * Community Paramedic: certain services provided by a community paramedic. The services must be a part of a care plan ordered by your primary care provider. The services may include: * Health assessments * Chronic disease monitoring and education * Help with medications * Immunizations and vaccinations * Collecting lab specimens * Follow-up care after being treated at a hospital * Other minor medical procedures * Hospital In-Reach Community-Based Service Coordination (IRSC): coordination of services targeted at reducing hospital emergency room (ER) use under certain circumstances. This service addresses health, social, economic, and other needs of members to help reduce usage of ER and other health care services. * Services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic under a governmental unit * Tuberculosis care management and direct observation of drug intake | $0 |
|  | [Add the apple icon if listing only preventive services.]  Hearing services  The plan pays for 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.  We cover additional items and services, including:   * Hearing aids and batteries * Repair and replacement of hearing aids due to normal wear and tear, with limits   [List any additional benefits offered, such as routine hearing exams, hearing aids, and evaluations for fitting hearing aids.] | [List copays.]  [List copays for additional benefits.] |
|  | [If this benefit is not applicable, plans should delete this row.]  Help with certain chronic conditions  [Plans that offer 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, plans 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 indicates preventive services. | HIV screening  The plan pays for one HIV screening exam every 12 months for people who:   * ask for an HIV screening test, **or** * are at increased risk for HIV infection.   Additional benefits may be covered by us.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Home health agency care  [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.  The plan will pay for the following services, and maybe other services not listed here:   * Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) * Physical therapy, occupational therapy, and speech therapy * Medical and social services * Medical equipment and supplies * Respiratory therapy * Home Care Nursing (HCN) * Personal care assistant (PCA) services and supervision of PCA services (Community First Services and Supports (CFSS) replaces PCA services when the State of Minnesota gets Federal approval to provide this service.) | [List copays.] |
|  | **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 can get care from any hospice program certified by Medicare.  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. Your hospice doctor 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   **Hospice services and services covered by Medicare Part A or Medicare Part B are billed to Medicare.**   * Refer to Section F of this chapter for more information.   **For services covered by the plan but not covered by Medicare Part A or Medicare Part B:**   * The plan will cover plan-covered services not covered under Medicare Part A or Medicare Part 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 the plan’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 [plans may insert reference, as applicable].   This benefit is continued on the next page | $0 |
|  | Hospice care (continued)  **Note:** If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should replace the term “care coordinator” with the term they use and 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.] |  |
|  | Housing stabilization services  The plan will pay for the following services for members eligible for Housing Stabilization Services:   * Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services * Housing transition services to help you plan for, find, and move into housing * Housing sustaining services to help you maintain housing * Transportation to get housing stabilization services   You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager.  If you have a targeted case manager or waiver case manager or senior care coordinator, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you.  Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to get this service. DHS will send you a letter of approval or denial for Housing Stabilization Services. |  |
| Apple icon indicates preventive services. | Immunizations  The plan will pay for the following services:   * Pneumonia vaccine * Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary * Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B * Other vaccines if you are at risk and they meet Medicare Part B coverage rules   The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Inpatient hospital care  [List any restrictions that apply.]  The plan will pay for the following services, and maybe other services not listed here:   * 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 * X-rays and other radiology services * Needed surgical and medical supplies * Appliances, such as wheelchairs * Operating and recovery room services * Physical, occupational, and speech therapy * Inpatient substance use disorder services * Blood, including storage and administration * The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. * Physician services * In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. For heart transplants this also includes a Ventricular Assist Device inserted as a bridge or as a destination therapy treatment.   **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)  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If the plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.] |  |
|  | Inpatient mental health care  The plan will pay for mental health care services that require a hospital stay, including extended psychiatric inpatient hospital stays. | $0 |
|  | Interpreter services  The plan will pay for the following services:   * Spoken language interpreter services * Sign language interpreter services | $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 doctor must refer you. The plan will cover up to six sessions of kidney disease education services. * Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plans may insert reference, as applicable] * 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 indicates preventive services. | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you meet all of the following:   * Are aged 55-77, **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 30 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 |
|  | Medical Assistance (Medicaid) covered prescription drugs  The plan will cover some Medical Assistance (Medicaid) covered drugs that are not covered by Medicare Part B and Medicare Part D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins.  The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that:   * the drug that is normally covered has caused a harmful reaction to you; **or** * there is a reason to believe the drug that is normally covered would cause a harmful reaction; **or** * the drug prescribed by your doctor is more effective for you than the drug that is normally covered.   The drug must be in a class of drugs that is covered.  If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our plan. If the pharmacy won’t call your doctor, you can. You can also call Member Services at the number at the bottom of this page. | $0 |
| Apple icon indicates preventive services. | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [insert as appropriate: referred **or** ordered] by your doctor.  The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s [insert as appropriate: referral **or** order].  A doctor must prescribe these services and renew the [insert as appropriate: referral **or** order] each year if your treatment is needed in the next calendar year.  We may cover additional benefits if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| 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  [*Plans that will or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that will or may be subject to Medicare Part B step therapy as well as a link to a list of drugs that will be subject to Medicare 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 Medicare Part B. The plan 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 Surgical Center (ASC) services * Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan * Clotting factors you give yourself by injection if you have hemophilia * Immunosuppressive drugs, 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 doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself * Antigens * Certain oral anti-cancer drugs and anti-nausea drugs * Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) * IV immune globulin for the home treatment of primary immune deficiency diseases   [Insert if applicable: The following link will take you to a list of Medicare Part B drugs that may be subject to step therapy: <hyperlink>.]  **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B prescription drugs (continued)**  We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit.  Chapter 5 [plans may insert reference, as applicable] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [plans may insert reference, as applicable] explains what you pay for your outpatient prescription drugs through our plan. |  |
|  | Mental health services  Refer to the following sections for covered mental health services [plans may insert reference, as applicable]:   * Depression screening * Inpatient mental health care * Outpatient mental health care * Partial hospitalization services | $0 |
|  | [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Nursing facility care  The plan is responsible for paying a total of 180 days of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the 180 days, the Minnesota Department of Human Services (DHS) will pay directly for your care.  If DHS is currently paying for your care in the nursing home, DHS, not the plan, will continue to pay for your care.  Refer to the “Skilled nursing facility (SNF) care” section of this chart for more information about the additional nursing home coverage the plan provides. | [List copays.] |
| Apple icon indicates preventive services. | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, 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 provider to find out more.  We may cover additional benefits if medically necessary.  [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 counseling * Individual and group therapy * Testing for drugs, chemicals, or substances 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, and maybe other services not listed here:   * 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 * Lab tests * Blood, beginning with the first pint of blood that you need. The plan will pay for storage and administration beginning with the first pint of blood you need. * Other outpatient diagnostic tests   [Plans 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, and maybe other services not listed here:   * 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/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf) * Labs and diagnostic tests billed by the hospital * Mental health care, including care in a partial-hospitalization program, if a doctor 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   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Outpatient mental health care  The plan will pay for mental health services provided by any of the following:   * a psychiatrist or doctor * a clinical psychologist * a clinical social worker * a clinical nurse specialist * a nurse practitioner * a physician assistant * a Tribal certified professional * a mental health rehabilitative professional * a Licensed Professional Clinical Counselor (LPCC) * a licensed marriage and family therapist * any other Medicare-qualified mental health care professional as allowed under applicable state laws   The plan will pay for the following services, and maybe other services not listed here:   * Certified Community Behavioral Health Clinic (CCBHC) * Clinical care consultation * Crisis response services including screening, assessment, intervention, stabilization (including residential stabilization), and community intervention * Diagnostic assessments including screening for presence of co-occurring mental illness and substance use disorders   **This benefit is continued on the next page** | $0  [List copays for additional benefits.] |
|  | **Outpatient mental health care** **(continued)**   * Dialectical Behavioral Therapy (DBT) * Intensive Outpatient Program (IOP) * Mental health provider travel time * Mental Health Targeted Case Management (MH-TCM) * Forensic Assertive Community Treatment (FACT) * Outpatient mental health services, including explanation of findings, mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family, crisis and group), and psychological testing * Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management * Rehabilitative Mental Health Services, including Assertive Community Treatment (ACT), Adult day treatment, Adult Rehabilitative Mental Health Services (ARMHS), Certified Peer Specialist (CPS) support services in limited situations, Intensive Residential Treatment Services (IRTS), and Partial Hospitalization Program (PHP) * Telemedicine   If we decide no structured mental health treatment is necessary, you may get a second opinion. For the second opinion, we must allow you to use any qualified health professional that is not in the plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.  We will not determine medical necessity for court-ordered mental health services. Use a plan network provider for your court-ordered mental health assessment.  [List any additional benefits offered.] |  |
|  | [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Outpatient rehabilitation services  The plan will pay for physical therapy, occupational therapy, and speech therapy.  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | Outpatient surgery  The plan will pay for outpatient surgery and services at hospital outpatient facilities and Ambulatory Surgical Centers (ASCs). | $0 |
|  | [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Partial hospitalization 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 or therapist’s office. It can help keep you from having to stay in the hospital.  [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 (ASC) * hospital outpatient department * Consultation, diagnosis, and treatment by a specialist * Basic hearing and balance exams given by your [insert as applicable:primary care [insert as appropriate:physician **or** provider] **or**specialist], if your doctor 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 Medicare 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. [*Plans 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 Medicare 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  [List copays for additional benefits.] |
|  | 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 or Medical Assistance (Medicaid)] * 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 * 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**   + the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment   This benefit is continued on the next page |  |
|  | Physician/provider services, including doctor’s office visits (continued)   * 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 care. 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. * For information about other dental services we cover, refer to the “Dental services” section of this chart. * Preventive and physical exams * Family Planning services. For more information, refer to the “Family planning” section of this chart.   [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 when medically necessary including conditions affecting the legs, such as diabetes * Other non-routine foot care such as debridement of toenails and infected corns and calluses   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Prostate cancer screening exams  For men, the plan will pay for the following services once every 12 months:   * A digital rectal exam * A prostate specific antigen (PSA) test   [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | [Plans should modify this section to reflect plan-covered additional benefits as appropriate.]  Prosthetic devices and related supplies  Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here:   * 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) * Orthotics * Wigs for people with alopecia areata * Some shoes when a part of a leg brace or when custom molded.   The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.  The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this section [plans 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  [List copays for additional benefits.] |
| Apple icon indicates preventive services. | Sexually transmitted diseases (STDs) screening and counseling  The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care [insert as appropriate: physician **or** provider] must order the tests. We cover these tests once every 12 months.  The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STDs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care [insert as appropriate: physician **or** provider]. The sessions must be in a primary care setting, such as a doctor’s office.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Skilled nursing facility (SNF) care  For additional nursing home services covered by us, refer to the “Nursing facility care” section.  [List days covered and any restrictions that apply, including whether any prior hospital stay is required.]  The plan will pay for the following services, and maybe other services not listed here:   * 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 and packed red cells beginning with the first pint of blood you need. * Medical and surgical supplies given by nursing facilities * 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   **This benefit is continued on the next page** | $0 |
|  | Skilled nursing facility (SNF) care (continued)  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 |  |
| Apple icon indicates preventive services. | Smoking and tobacco use cessation  If you use tobacco but do not have signs or symptoms of tobacco-related disease:   * The plan will pay for two attempts to quit with counseling in a 12-month period as a preventive service. * This service is free for you. Each counseling attempt includes up to four face-to-face visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * The plan will pay for two attempts to quit with counseling within a 12-month period. Each counseling attempt includes up to four face-to-face visits.   We may cover additional benefits if medically necessary.  [List any additional benefits offered.] | $0  [List copays for additional benefits.] |
|  | Substance use disorder services  The plan pays for the following services:   * Screening/assessment/diagnosis * Outpatient treatment * Inpatient hospital * Residential non-hospital treatment * Outpatient methadone treatment * Substance use disorder treatment coordination * Peer recovery support * Detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or medical complications during detoxification) * Withdrawal management   A qualified assessor who is a part of our plan’s network will decide what type of substance use disorder care you need. You may get a second assessment if you do not agree with the first one. To get a second assessment you must send us a request. We must get your request within five working days of when you get the results of your first assessment or before you begin treatment (whichever is first). We will cover a second assessment by a different qualified assessor We will do this within five working days of when we get your request. If you agree with the second assessment, we will authorize services according to substance use disorder standards and the second assessment.  You have the right to appeal. Refer to Chapter 9 [plans may insert reference, as applicable].  [Describe the plan’s benefits for outpatient substance use disorder services.] | [List copays.] |
|  | **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 |
|  | Transportation  If you need transportation to and from health services that we cover, call [insert: <phone number>]. We will provide the most appropriate and cost-effective transportation. Our plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call [insert: <phone number>] if you do not have a Primary Care Clinic that is available within 30 miles of your home and/or you do not have a specialty provider that is available within 60 miles of your home.   * Non-emergency ambulance * Volunteer driver transport * Unassisted transport (taxi or public transportation) * Assisted transportation * Lift-equipped/ramp transport * Protected transportation * Stretcher transport   **Note:** Our plan does not cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking, also including out of state travel. These services are not covered under the plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.  [*MCOs may include additional information on how to access transportation services*. *MCOs are not allowed to include information regarding a penalty for missed rides.*] | $0 |
|  | Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency, **or** * a sudden medical illness, **or** * an 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.  [Include in-network benefits.]  This coverage is only available within the U.S. and its territories. | $0 |
| Apple icon indicates preventive services. | [Plans should modify this section to reflect plan-covered additional benefits as appropriate. Add the apple icon if listing only preventive services.]  Vision care  The plan will pay for outpatient doctor 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 for one glaucoma screening each year. People at high risk of glaucoma include:   * people with a family history of glaucoma, * people with diabetes, * African-Americans, **and** * Hispanic Americans.   **This benefit is continued on the next page** | $0  [List copays for additional benefits.] |
|  | Vision care (continued)  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.)  We also cover the following:   * Eye exams * Initial eyeglasses, when medically necessary. Selection may be limited. * Replacement eyeglasses, when medically necessary. Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair. * Repairs to frames and lenses for eyeglasses covered under the plan * Tints, photochromatic (such as Transitions®) lenses, or polarized lenses, when medically necessary * Contact lenses, when medically necessary under certain circumstances   [Also list any additional benefits offered, such as additional vision exams or glasses.]  [*Insert if applicable and include only items not covered by the plan:* **Note:** Our plan does not cover an extra pair of glasses, bifocal/trifocal lenses without lines and progressive bifocals/trifocals, protective coating for plastic lenses, and contact lens supplies.] |  |
| Apple icon indicates preventive services. | “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 doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

# Our plan’s visitor or traveler benefits

[If your plan offers a visitor/traveler program to members who are out of your service area, insert this section, adapting and expanding the following paragraphs as needed to describe the traveler benefits and rules related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below:

If you are out of the plan’s service area for more than 6 months at a time, we usually must drop you from our plan. However, we offer a visitor/traveler program [specify areas where the visitor/traveler program is being offered] that will allow you to remain enrolled in our plan when you are outside of our service area for up to 12 months. This program is available to all <plan name> members who are in a visitor/traveler area. Under our visitor/traveler program, you can get all plan-covered services at in-network cost sharing prices. You can contact the plan for help in finding a provider when you use the visitor/traveler benefit.

If you are in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you have not returned to the plan’s service area by <end date>, you will be dropped from the plan.]

# Benefits covered outside of <plan name>

The following services are not covered by <plan name> but are available through Medicare.

## F1. Hospice care

You can get care from any hospice program certified by Medicare. 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. Your hospice doctor 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 Medicare Part 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 Medicare Part B that are not related to your terminal prognosis** **(except for emergency care or urgently needed care):**

* The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part 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 [plans may insert reference, as applicable].

**Note:** If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [Plans should replace the term “care coordinator” with the term they use and include a phone number or other contact information.]

## F2. Other Services

The following services are not covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these services, call the Minnesota Health Care Programs Member Helpdesk at 651-431-2670 or 1-800-657-3739 (toll-free). TTY users should call 1-800-627-3529.

* Case management for people with developmental disabilities
* Intermediate care facility for people who have a developmental disability (ICF/DD)
* Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS)
* Room and board associated with Intensive Residential Treatment Services (IRTS)
* Services provided by a state regional treatment center or a state-owned long-term care facility unless approved by us or the service is ordered by a court under conditions specified in law
* Services provided by federal institutions
* Except Elderly Waiver services, other waiver services provided under Home and Community-Based Services waivers
* Job training and educational services
* Day training and habilitation
* Mileage reimbursement (for example, when you use your own car), meals, lodging, and parking. Contact your county for more information.
* Nursing home stays for which our plan is not otherwise responsible. (Refer to the “Nursing facility care” and the “Skilled nursing facility (SNF) care” sections in the Benefits Chart for additional information.)
* Room and board for substance use disorder treatment as determined necessary by substance use disorder assessment
* Medical Assistance (Medicaid) covered services provided by Federally Qualified Health Centers (FQHCs)

# Benefits not covered by <plan name>, Medicare, or Medicaid (Medical Assistance)

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

* Services considered not “reasonable and necessary,” according to the standards of Medicare and Medical Assistance (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 [plans 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 and/or Medical Assistance (Medicaid) pays for it.
* 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.
* Fees charged by your immediate relatives or members of your household. Exceptions to this may be for some services, such as personal care assistance (PCA) and consumer-directed community supports (CDCS) services.
* 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.
* Routine foot care, except for the limited coverage listed in the Benefits Chart.
* LASIK surgery.
* Reversal of sterilization procedures.
* 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 the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference.