Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan 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 this *Member Handbook*.

[*Plans should refer to other parts of the Member Handbook using the appropriate chapter number and section. For example, "refer* ***to Chapter 9****, Section A." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Member Handbook. Plans can always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]

[*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] 3](#_Toc199836451)

[B. Rules against providers charging you for services 3](#_Toc199836452)

[C. About our plan’s Benefits Chart 3](#_Toc199836453)

[D. Our plan’s Benefits Chart 9](#_Toc199836454)

[E. Extra “Optional Supplemental” benefits you can buy 92](#_Toc199836455)

[F. Our plan’s visitor or traveler benefits 93](#_Toc199836456)

[G. Benefits covered outside of our plan 93](#_Toc199836457)

[G1. Other Services 94](#_Toc199836458)

[H. Benefits not covered by our plan, Medicare, or Medical Assistance 95](#_Toc199836459)

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

This chapter tells you about services our plan covers [*insert if the plan has cost-sharing*: and how much you pay for each service]. You can also learn about services that aren’t covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. [*Insert if applicable*: This chapter also explains limits on some services.]

[*Plans with cost-sharing, insert*: For some services, you’re charged an out-of-pocket cost called a copay. This is a fixed amount (for example, $5) you pay each time you get that service. You pay the copay at the time you get the medical service.]

[*MSHO/SNBC plans use this statement: Plans with* ***no*** *cost-sharing for any services described in this chapter, insert*: Because you get help from Medical Assistance you pay nothing for your covered services as long as you follow our plan’s rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan’s rules.]

If you need help understanding what services are covered, call [*insert*: your care coordinator and/or Member Services at <phone number(s)>].

# Rules against providers charging you for services

We don’t allow our providers to bill you for in network 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** of this *Member Handbook* or call Member Services.

# About our plan’s Benefits Chart

[*Plans can add references to long-term care or home and community-based services*.]

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them. [*MSHO/SNBC use this statement: 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 pay for the services listed in the Benefits Chart when the following rules are met.** [*Plans that don’t have cost-sharing, insert*: You **don’t** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.]

* We provide covered Medicare and Medical Assistance covered services according to the rules set by Medicare and Medical Assistance
* The services [*Minnesota plans should use the information below which revises this language as allowed;* *Plans can revise as applicable*: *(including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs*)] must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice. [*Plans may revise and use the state-specific definition of “medically necessary” and ensure that it‘s updated and used consistently in* ***Chapter 12*** *and throughout member materials.*]
* [*MSHO/SNBC plans insert based on instructions above*]Medically necessary care is appropriate for your condition. This includes care related to physical conditions and behavioral heatlh (including Mental Health and Substance Use Disorder). 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 drugs 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.
* For new members for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
* [*Insert if applicable*: You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won’t be covered unless it’s an emergency or urgently needed care, or unless your plan or a network provider gave you a referral. **Chapter 3** of this *Member Handbook* 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 providing and managing your care. [*Plans that don’t require referrals, omit the rest of this paragraph*:] In most cases, your PCP must give you approval before you can use a provider that isn’t your PCP or use other providers in our plan’s network. This is called a referral. **Chapter 3** of this *Member Handbook* has more information about getting a referral and when you **don’t** need one.]
* [*Plans can add information about any continuity of care requirements as directed by the state*. *Minnesota plans should add the following:*
* If a provider you choose is no longer in our plan network, you must choose another plan network provider. You may be able to continue to use services from a provider who is no longer a part of our plan network for up to 120 days for the following reasons:
* An acute condition.
* A life-threatening mental or physical illness.
* A physical or mental disability defined as an inability to engage in one or more major life activities. This applies to a disability that has lasted or is expected to last at least one year, or is likely to result in death.
* A disabling or chronic condition that’s in an acute phase.
* If your [*plan should insert*: doctor *or* qualified health care provider] certifies that you have an expected lifetime of 180 days or less, you may be able to continue to use services for the rest of your life from a provider who is no longer part of our network.
* [*Insert if applicable*: We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA [*insert as appropriate*: with an asterisk (\*) *or* with a footnote *or* in bold type *or* in italic type].] [*Insert if applicable*: In addition, you must get PA for the following services not listed in the Benefits Chart: [*insert list*].] If we provide approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider’s recommendations.

[*Insert* *if offering Special Supplemental Benefits for the Chronically Ill (SSBCI):* **Important Benefit Information for Members with Certain Chronic Conditions.**

* If you have any of the chronic condition(s) listed below 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*.]
* [*Include information about the process and/or criteria for determining eligibility for SSBCI*.]
* Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.]
* Contact us for additional information.

[*Insert as applicable*: Most ***or*** All] preventive services are free. This apple Apple icon represents preventive services in the benefits chart. shows the preventive services in the Benefits Chart.

[*Insert any additional applicable Medicaid program coverage here such as community supports.*]

Restricted Recipient Program

* The Restricted Recipient Program is for members who’ve misused health services. This includes getting health services that members didn’t need, using them in a way that costs more than they should, or in a way that may be dangerous to a member’s health. <MCO Name> will notify members if they’re placed in the Restricted Recipient Program.
* If you’re in the Restricted Recipient Program, you must get health services from one designated primary care provider [*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 won’t be allowed to use the personal care assistance choice or flexible use options or consumer directed services. You won’t be able to use the Community First Services and Supports (CFSS) budget model.
* You’ll 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 won’t 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’ll 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. You may request a State Appeal (Fair Hearing with the state) after receiving our decision that we have decided to enforce the restriction. Refer to **Chapter 9**, **Section F3** for more information about your right to appeal.
* The Restricted Recipient Program doesn’t 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 or benzodiazepine medications isn’t 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 don’t need to include the given description (unless it’s still applicable) and can instead describe the plan benefit.*
* *Optional supplemental benefits aren’t permitted in this chart; optional supplemental benefits should be described in Section E.*
* *Include the following where appropriate: Talk to your provider and get a referral.*
* *Plans must include any services provided in excess of the Medicare and Medicaid requirements and identify preventive services 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 PA. (This can be done with asterisks, footnotes, bold type, or italic type. Plans must 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 can insert any additional benefit information that is based on the plan’s approved benefit package and not already included in the Benefits Chart or in the exclusions section. Plans insert any additional benefits in the chart alphabetically.*
* *Plans must add any Medicaid benefits covered to the chart as instructed by the state. Insert any additional benefits in the chart alphabetically. If directed by the state, include all non-waiver services in the chart and all HCBS waiver services as a separate section after the chart. Each 1915(c) waiver should be listed separately, with the appropriate services also listed. The remainder of the sections should then be renumbered.*
* *Plans must describe any restrictive policies, limitations, or monetary limits that might affect a member’s access to services within the chart.*
* *Plans can 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 doesn’t resemble any exclusion, then the plan shouldn’t reference the exclusion list.*
* *Plans should include all non-waiver LTSS in the chart in alphabetical order.*
* *Plans with no cost-sharing for any type of service (i.e., no cost-sharing at all) may delete the “what you must pay” column from the table. Plans with any type of cost-sharing for services, including for pharmacy services, must leave the “what you must pay” column in the table.*
* *Plans offering targeted supplemental benefits in Section B-19 of the Plan Benefit Package submission must:*
* *Deliver to each clinically-targeted member a written summary of those benefits so that such member are notified of the “Uniformity Flexibility” benefits for which they’re 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*.]

# Our plan’s 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 in bold followed by* **(continued)**. *Plans may refer to* **Durable medical equipment (DME) and related supplies** *and other benefits 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*.]

[*Plans should modify this section throughout to reflect Medicaid, Medicaid in lieu of services, or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid*. *When adding Medicaid in lieu of services, plans must add this notes language to the benefit:* Notes: Members aren’t required to use this service. If you choose to use this service, you keep all your rights. Your health plan can’t deny access to any services just because you were offered, are using, or have used this service before*.*]

| Covered Service | | What you pay |
| --- | --- | --- |
| Apple indicates preventive benefit. | Abdominal aortic aneurysm screening  We pay for a one-time ultrasound screening for people at risk. Our 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  Acupuncture services are covered when provided by a licensed acupuncturist or by another Minnesota licensed practitioner with acupuncture training and credentialing.  We pay for up to 12 acupuncture 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.   In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.  Acupuncture treatments must be stopped if you don’t get better or if you get worse.  In addition, we’ll pay for up to 20 units of acupuncture services per calendar year without authorization. Ask for prior authorization if additional units are needed.  Acupuncture services are covered for the following:   * acute and chronic pain * depression * anxiety * schizophrenia * post-traumatic stress syndrome * insomnia * smoking cessation * restless legs syndrome   **This benefit is continued on the next page** | [*List copays for additional benefits*.] |
|  | Acupuncture (continued)   * menstrual disorders * xerostomia (dry mouth) associated with the following: * Sjogren’s syndrome * radiation therapy * nausea and vomiting associated with the following: * post-operative procedures * pregnancy * cancer care   Provider Requirements:  Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.  Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of (the Act)), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:   * a master’s or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, * a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.   Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.  [*List any additional benefits offered*.] |  |
| Apple icon indicates preventive services. | Alcohol misuse screening and counseling  We pay for one alcohol-misuse screening for adults who misuse alcohol but aren’t alcohol dependent. This includes pregnant women.  If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you’re able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.  (refer to the “Outpatient substance use disorder services” section of this chart for additional covered benefits.)  [*List any additional benefits offered*.] | $0 |
|  | Ambulance services  Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and 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 health or life.  Ambulance services for other cases (non-emergency) must be approved by us. In cases that aren’t emergencies, we 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  You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.  **Note:** Your first annual wellness visit can’t take place within 12 months of your **Welcome to Medicare** visit. However, you don’t need to have had a **Wecome to Medicare** visit to get annual wellness visits after you’ve had Part B for 12 months.  [*List any additional benefits offered*.] | $0 |
| Apple icon indicates preventive services. | Bone mass measurement  We 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.  We pay for the services once every 24 months, or more often if medically necessary. We 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)  We pay for the following services:   * one baseline mammogram between the ages of 35 and 39 [*plans that only cover ages 65 and over should delete*] * one screening mammogram every 12 months [*plans that cover women under 65 should include:* for women aged 40 and over] * clinical breast exams once every 24 months   [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | Cardiac (heart) rehabilitation services  We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor’s [*insert as appropriate*: referral ***or*** order].  We also cover 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)  We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the [visit ***or*** visits], your doctor may:   * discuss aspirin use, * check your blood pressure, **and/or** * give you tips to make sure you’re eating well.   [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease screening tests  We pay 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.  [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | [*Insert*: Care Coordination *or* other title used by health plan]  [*For MSHO insert:* We pay 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.*]  [*SNBC Insert:* You’re assigned a [county case manager *or* care coordinator] who will help connect you to the services and resources you need to get the best possible care. [County case managers *and* Care coordinators] can also help you learn more about your health, any health conditions you have, and help you follow your <*choose the term your plan uses*: plan of care, support plan, care plan>. [County case managers can go to health care appointments with you if you’d like them to.] Care coordinators and <Plan Name> <Member Services> staff are available to answer questions about <Plan Name> and the SNBC program.]  [*MCO should describe how to access this service and list any additional benefits offered. The MCO should add information on care coordination specific to the MCO. Suggest including methods of communications available with their care coordinator (i.e. Talk, Text, Email, Chat, Meet in Person*)]  This benefit is continued on the next page |  |
|  | [*Insert*: Care Coordination *or* other title used by health plan] (continued)  [County case management *and* Care coordination] [*are*/*is*] always available for you. You can stop using [*these* services/*this* service] at any time by telling your [county case manager/care coordinator *or* by contacting <Plan name>]. If you want to change your [county case manager *or* care coordinator, <*insert how to request*>]. [If you’re offered county case management and don’t want to work with a county case manager, you can ask for a <Plan name> care coordinator to work with you instead.]  We pay for the following services:   * an assessment to identify how the care coordinator can help you with health care, housing, food security, and other needs * help with scheduling, coordinating, and receiving assessments or tests and health care services such as dental, behavioral health, rehabilitative, and primary care * creation and updating of your <choose the term your plan uses: support plan, care plan, plan of care>, based on your unique needs and working with the people you choose * with your permission, our care coordinators can communicate with agencies and people who can help meet your needs: * work together with you and others you choose when you have a change in your health care needs or a hospitalization * help you find resources you need in your community * work together with your Home and Community Based Services waiver case managers or other case managers   This benefit is continued on the next page |  |
|  | [*Insert*: Care Coordination *or* other title used by health plan] (continued)   * with your participation, our care coordinators also do the following: * help you set goals for your health and well-being and work with you to reach them * communicate or meet with you regularly to discuss your health and well-being * remind you when you need preventive services, tests, or appointments that are part of your <choose the term your plan uses: support plan, plan of care, care plan> * [*Plans may include additional Care Coordination services.*]   [*Also describe how to access this service and list any additional benefits offered*.] |  |
| Apple icon indicates preventive services. | Cervical and vaginal cancer screening  We 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 * [*Plans that cover women under 65 must include:* for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months]   [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | [*Insert for SNBC*]  Child and Teen Checkups (C&TC)  These preventive well-child visits look at growth, development, and overall health. According to the Minnesota C&TC Schedule of Age-Related Screening Standards ([**edocs.dhs.state.mn.us/lfserver/public/DHS-3379-ENG**](https://edocs.dhs.state.mn.us/lfserver/public/DHS-3379-ENG)) these checkups are meant to keep kids healthy by finding any heatlh concerns or problems early. Finding health concerns early prevents them from becoming bigger problems later. Keeping healthy means you**’**re more likley to grow into a healthy adult.  Depending on age these visits may include:   * head-to-toe exam * immunizations and lab tests as needed * checks on development and growth * health history including nutrition * health education * hearing and vision checks * information on good physical and mental health * time to ask questions and get answers about health, behavior, and development and talk about learning, feelings, relationships, parenting, and caregiver well-being * fluoride varnish to keep teeth healthy and dental referrals   C&TC is a health care benefit promoting health visits for children members under 21 years old.  Each visit may include one-on-one time with the health care provider. This gives time for young adults to ask questions privately and learn to manage their own health.  Members under age 21 should contact their Primary Care Clinic to schedule C&TCpreventive health visits. |  |
|  | Chiropractic services  [*Insert for SNBC*:For members age under age 21, we pay for the following services:   * adjustments of the spine to correct alignment * one evaluation or exam per calendar year * manual manipulation (adjustment) of the spine to treat subluxation of the spine – up to 24 treatments per calendar year, limited to six per month. (Treaments exceeding 24 per calendar year or six per month require a prior authorization.) * x-rays when needed to support a diagnosis of subluxation of the spine   For members age 21 and older:  [*If plan only pays for manual manipulation, insert:*We pay for only] Manual manipulation of the spine to correct subluxation  [*Also list any additional benefits offered.*]  Note: Our plan doesn’t cover other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor.  [*List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits*.]]  [*Insert for MSHO:* [*If plan only pays for manual manipulation, insert:*We pay for only] Manual manipulation of the spine to correct subluxation  [*Also list any additional benefits offered.*]  Note: Our plan doesn’t cover other adjustments, vitamins, medical supplies, therapies, and equipment from a chiropractor.  [*List any Medicaid or plan-covered supplemental benefits offered. Also list any restrictions, such as the maximum number of visits*.]] | [*List copays*.]  [*List copays for supplemental benefits*.] |
|  | Chronic pain management and treatment services  Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. |  |
| Apple icon indicates preventive services. | Colorectal cancer screening  We pay for the following services:   * Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren’t at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. * Computed tomography colonography for patients 45 years and older who aren’t at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonsocopy was performed. * Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. * Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. * Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. * Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.   **This benefit is continued on the next page** | $0  [*List copays for additional benefits*.] |
|  | Colorectal cancer screening (continued)   * Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.   [*List any additional benefits offered*.] |  |
|  | [*Modify to accurately describe the Medicaid and/or supplemental benefit offered*.]  Dental services  Certain dental services, including cleanings, fillings, and dentures, are available through the Medical Assistance Dental Program.  IMPORTANT: This isn’t a comprehensive list. Specific coverage isn’t guaranteed.  Service limits may apply to services listed in the following dental section. Some services may or may not require <service/prior> authorization due to medical necessity. To find out more about these services, contact Member Services at the number at the bottom of the page.  We pay for the following services:  Diagnostic services:   * exam and oral evaluation * imaging services, which inlcude: * bitewing * single X-rays for diagnosis of problems * panoramic * full mouth X-rays   **This benefit is continued on the next page** | [*If plan offers supplemental benefit, the maximum copay amount is $10*.] |
|  | **Dental services (continued)**  Preventive services:   * cavity arresting treatment * dental cleaning(s) * fluoride varnish * sealants * oral hygiene instruction   Restorative services:   * fillings * sedative fillings for relief of pain * individual crowns, restricted to resin and stainless steel   Endodontics (root canals)  Oral surgery   * tooth extractions   Orthodontics (with <service/prior> authorization )  Periodontics:   * gross removal of plaque and tartar   This benefit is continued on the next page |  |
|  | **Dental services (continued)**   * scaling and root planing * follow-up procedures (periodontal maintenance) (for two years following scaling and root planing)   Prosthodontics:   * removable appliances (dentures,partials,overdentures) (one appliance every 3 years per dental arch); (partials always require a <service/prior> authorization) * adjustments, modifications, relines, repairs, and rebases of removable appliances (dentures and partials) * replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances * replacement of partial appliances if the existing partial can’t be altered to meet dental needs * tissue conditioning liners * precision attachments and repairs   Additional general dental services:   * emergency treatment of dental pain * general anesthesia, deep sedation   This benefit is continued on the next page |  |
|  | **Dental services (continued)**   * extended care facility/house call in certain institutional settings including: nursing facilities, skilled nursing faciliites, boarding care homes, Institutions for Mental Diseases (IMD), Intermediate Care Facilities for Persons with Developmental Disabilities(ICF/DDs), 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 * medications (only when medically necessary for very limited conditions) * nitrous oxide * oral bite adjustments * oral or IV sedation   Notes:  If you choose to get dental benefits from a federally qualified health center (FQHC) or a state-operated dental clinic, you’ll have the same benefits that you’re entitled to under Medical Assistance.  If you’re new to our health plan and have already started a dental service treatment plan, contact us for coordination of care.  This benefit is continued on the next page |  |
|  | **Dental services (continued)**  If you begin orthodontia services, we won’t require completion of the treatment plan to pay the provider for services received.  We pay for some dental services when the service is an integral part of specific treatment of a person’s primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.  [*Plans that offer optional supplemental dental benefits at an additional cost insert*: Note: Our plan offers additional dental services. Go to the Benefits Chart in Section E for more information.] |  |
| Apple icon indicates preventive services. | Depression screening  We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or 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  We 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’re overweight and have a family history of diabetes.  You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.  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  We 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, we pay for the following: * one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** * one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) * In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.   [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | Durable medical equipment (DME) and related supplies  Refer to **Chapter 12** of this *Member Handbook* for a definition of “Durable medical equipment (DME).”  We cover the following items:   * wheelchairs * crutches * powered mattress systems * diabetic supplies (For diabetic supplies refer to the “Diabetic self-management training, services, and supplies” section in this benefit chart.) * hospital beds ordered by a provider for use in the home * intravenous (IV) infusion pumps and pole * speech generating devices * oxygen equipment and supplies * nebulizers * walkers * standard curved handle or quad cane and replacement supplies * cervical traction (over the door) * bone stimulator * dialysis care equipment * We cover additional items, including: * repairs of medical equipment * batteries for medical equipment * airway clearance devices * medical supplies you need to take care of your illness, injury or disability   **This benefit is continued on the next page** | [*List copays, including how they vary for equipment covered by Medicare and Medicaid, if applicable*.]  [*Include if applicable:* Your cost-sharing for Medicare oxygen equipment coverage is [*insert copay amount or coinsurance percentage*], every [*insert required frequency of payment*].]  [*Plans that use a constant cost-sharing structure for oxygen equipment insert:* Your cost-sharing won’t change after being enrolled for 36 months.] |
|  | Durable medical equipment (DME) and related supplies (continued)   * incontinence products * nutritional/enteral products when specific conditions are met * familly planning supplies (refer to the “Family planning services” section of this chart for more information) * augmentative communication devices, including electronic tablets * seizure detection devices   Other items may be covered.  [*Plans that don’t limit the DME brands and manufacturers that they cover, insert*:We pay for all medically necessary DME that Medicare and Medical Assistance usually pay for. If our supplier in your area doesn’t 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 they cover, insert the following* (for more information about this requirement, *refer to* ***Chapter 4*** *of the Medicare Managed Care Manual*): With this *Member Handbook*, we sent you our plan’s list of DME. The list tells you the brands and makers of DME that we pay for. You can also find the most recent list of brands, makers, and suppliers on our website at <URL>.  Generally, our plan covers any DME covered by Medicare and Medical Assistance from the brands and makers on this list. We don’t cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you’re new to our plan and using a brand of DME not on our list, we’ll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)  **This benefit is continued on the next page** | [*Plans that wish to vary cost-sharing for oxygen equipment after 36 months insert details including whether original cost-sharing resumes after 5 years and you’re still in the plan.*] [*If cost-sharing is different for members who made 36 months of rental payments prior to joining the plan insert:* If prior to enrolling in <plan name> is [*insert cost-sharing*].] |
|  | Durable medical equipment (DME) and related supplies (continued)  If you (or your doctor) don’t agree with our plan’s coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don’t agree with your doctor’s decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to Chapter 9 of this *Member Handbook*.] |  |
|  | [*Insert row for SNBC plans only*] Early Intensive Developmental and Behavioral Intervention (EIDBI) Services (for members under age 21)]  The purpose of the EIDBI benefit is to provide medically necessary, early and intensive intervention for people with Autism Spectrum Disorder (ASD) and related conditions. Families can learn more about EIDBI by taking the [pathlore.dhs.mn.gov/Courseware/DisabilityServices/EIDBI/EIDBI101\_F/index.html](https://pathlore.dhs.mn.gov/Courseware/DisabilityServices/EIDBI/EIDBI101_F/index.html) online training.  Families can learn more about autism, as well as resources and supports, by visiting the [Minnesota Autism Resource Portal](https://mn.gov/autism/) [(mn.gov/autism/)](https://mn.gov/autism/)).  The benefit is also intended to:   * educate, train and support parents and families * promote people’s independence and participation in family, school and community life   Improve long-term outcomes and the quality of life for people and their families.  EIDBI services are provided by enrolled EIDBI providers who have expertise in the approved modalities which include:   * [Applied Behavior Analysis (ABA)](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305627#ABA) * [Developmental, Individual Difference, Relationship-Based (DIR)/Floortime model](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305627#DIR) * [Early Start Denver Model (ESDM)](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305627#ESDM) * [PLAY Project](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305627#PLAY) * [Relationship Development Intervention (RDI)](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305627#RDI) * [Early Social Interaction (ESI)](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-305627#ESI)   [www.dhs.state.mn.us/EIDBI-TreatmentModalities](http://www.dhs.state.mn.us/EIDBI-TreatmentModalities )  **This benefit is continued on the next page** |  |
|  | (EIDBI) services (continued)  Covered services:   * [Comprehensive Multi-Disciplinary Evaluation](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195210) (CMDE) which is needed to determine eligibility and medical necessity for EIDBI services * [www.dhs.state.mn.us/CMDE](http://www.dhs.state.mn.us/CMDE) * Individual Treatment Plan (ITP) Development (Initial) * ITP Development and Progress Monitoring [www.dhs.state.mn.us/ITP](http://www.dhs.state.mn.us/ITP) * [Direct Intervention](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS16_195212): Individual, Group, and/or higher intensity   [www.dhs.state.mn.us/EIDBI-DirectIntervention](file:///C:\Users\Pwsrk53\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\2JMVOU9O\(https:\www.dhs.state.mn.us\EIDBI-DirectIntervention))   * Intervention Observation and Direction   [www.dhs.state.mn.us/EIDBI-ObservationandDirection](http://www.dhs.state.mn.us/EIDBI-ObservationandDirection)  Family/Caregiver Training and Counseling: Individual and/or Group  [www.dhs.state.mn.us/EIDBI-CaregiverTrainingandCounseling](http://www.dhs.state.mn.us/EIDBI-CaregiverTrainingandCounseling)   * Coordinated Care Conference   [www.dhs.state.mn.us/main/idcplg?IdcService=GET\_DYNAMIC\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\_195209](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_195209)   * Travel time |  |
|  | [*Insert row for MSHO plans only*] Elderly Waiver Services (Home and Community-Based Services)   * Adult Companion Services: Non-medical care, supervision and socialization. * Adult Day Services (ADS) and ADS Bath: Licensed individualized program of activities to meet the assessed health and social needs of an older adult. ADS Bath is optional. Also includes Family Adult Day services (FADS). * Adult Foster Care: Licensed, adult appropriate residential care and supportive services in a family-like setting. * Case Management: Provides you with access to assessment, person-centered planning, referral, linkage, support planning, coordination and advocacy for waiver services, resources, and informal supports. * Chore Services: Assistance for you or your primary caregiver with heavy household services to help maintain a clean, sanitary and safe environment. * Consumer Directed Community Support Services: An individualized set of supports designed to meet your needs that you manage within a set budget. * Customized Living/24-Hour Customized Living: A group of regularly scheduled, individualized services (health related and supported services) provided in a licensed assisted living facility or other qualified residential setting. * Environmental Accessibility Adaptations (EAA): Physical adaptations, including assessments and moifications, to your primary home or primary vehicle to ensure your health and safety or enable you to function with greater independence. * Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance limit.   **This benefit is continued on the next page** |  |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)   * Extended State Plan Home Care Nursing: This includes home care nursing services that are over the Medical Assistance limit. * Extended State Plan Personal Care Assistance (PCA) Services and Community First Services and Supports (CFSS). Help with personal care and activitites of daily living (ADLs) over the Medical Assistance limit. Direct support workers can also assist with covered instrumental activiites of daily living (IALDs). * Family Caregiver Services: Caregiver training and caregiver counseling. * Home Delivered Meals: An appropriate, nutritionally balanced meal delivered to your home. * Homemaker Services: Services that help you manage general cleaning and household activities. * Individual Community Living Support Services: A bundled service to offer assistance and support to remain in your own home including reminders, cues, intermittent supervision or physical assistance. * Respite Care: Short-term service when you can’t care for yourself, and your unpaid caregiver needs relief. * Specialized Equipment and Supplies: Supplies and equipment that are over the Medical Assistance limit or coverage or aren’t a part of other Medical Assistance coverage but are specified in your support plan. This includes the Personal Emergency Response System (PERS).   This benefit is continued on the next page |  |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)   * Transitional Services: Items and supports necessary to move from a foster care home, hospital or nursing home to an independent or semi-independent community-based housing. * Transportation (non-medical): Enables you to gain access to community activities and waiver services that are identified in your support plan.n the community.   You must have a MnCHOICES assessment, formerly called a Long-Term Care Consultation (LTCC) done and be found to meet nursing home level of care to get 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.  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.  This benefit is continued on the next page |  |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)  After the visit, your MSHO [*insert*: care coordinator *or* case manager] will send you an assessment suumary that recommends services that best meet your needs. You’ll also be sent a copy of the support 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 Nation’s health or human services division or through our plan. Contact the tribal nation or our plan if you have questions.  If you’re currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you’ll continue to get services covered by these programs in the same way you get them now. Your county or Tribal Nation 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 evaluate or treat a medical emergency.   A medical emergency is an illness,injury, severe pain, or medical condition that’s quickly getting worse. 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 life [*Plans that cover women under 65 must include*: or to that of your unborn child]; **or** * serious harm to bodily functions; **or** * loss of a limb, or loss of function of a limb. * [*Plans that cover women under 65 must include*:In the case of a pregnant woman in active labor, when: * There isn’t enough time to safely transfer you to another hospital before delivery. * A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.]   This coverage is only available within the U.S. and its territories. [*Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage*.] | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [*plans should insert information as needed to accurately describe emergency care benefits*: (e.g., you must move 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 our plan approves your stay.)]. |
|  | [*If family planning services are covered, plans should modify this as necessary*.]  Family planning services  The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. These are called open access services. This means any doctor, clinic, hospital, pharmacy or family planning office.  We pay for the following services:   * family planning exam and medical treatment * family planning lab and diagnostic tests * family planning methods (birth control pills, patch, ring, Intrauterine Device (IUD), injections, implants ) * family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) * counseling and diagnosis of infertility and related services * counseling and testing for sexually transmitted disease (STDs), AIDS, and other HIV-related conditions * treatment for sexually transmitted diseases (STDs) * voluntary sterilization – [*Insert for SNBC:*] You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery. * genetic counseling   We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:   * treatment for medical conditions of infertility (This service doesn’t include artificial ways to become pregnant.) * treatment for AIDS and other HIV-related conditions * genetic testing | [*List copays*.] |
| Apple icon indicates preventive services. | 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*.]  [*If this benefit isn’t applicable, plans should delete this row*.] | [*List copays*.] |
|  | Health services  We pay for the following services:   * Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist * allergy immunotherapy and allergy testing * Behavioral Health Home: coordination of primary care, mental health services and social services * 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 be typically 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 |  |
|  | 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   [*Insert for SNBC:* Enhanced asthma care services (for eligible members under the age of 21 who are diagnosed as having poorly controlled asthma, when specific criteria are met)   * home visits to determine if there are asthma-triggers in the member’s home. Visit must be provided by a registered environmental health specialist, healthy homes specialist, and lead risk assessor**.** Your local public health agency can help you find one of these health care professionals to help you or you can contact Member Services.]   This benefit is continued on the next page |  |
|  | Health services (continued)   * 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 * Telemonitoring: use of technology to provide care and support to a member’s complex health needs from a remote location such as in a member’s home. Telemonitoring can track a member’s vital signs using a device or equipment that sends the data electronically to their provider for review. Examples of vital signs that can be monitored remotely include heart rate, blood pressure, and blood glucose levels * Tuberculosis care management and direct observation of drug intake |  |
|  | [*Plans should modify this section to reflect plan-covered benefits as appropriate*.]  Hearing services  We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They’re 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 copays*.]  [*List copays for additional benefits*.] |
|  | [*If this benefit isn’t 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 submissio*n.] | [*List copays*.] |
| Apple icon indicates preventive services. | HIV screening  We pay 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.   If you’re pregnant, we pay for up to three HIV screening tests during a pregnancy.  Additional benefits may be covered by us.  [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | [*SNBC insert*: Home and Community Based Service Information  Your SNBC [*insert either:* care coordinator or case manager] will give you information about community services. A county worker will 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. This information can be given to you by mail, phone, or in person.  If you choose to have a visit, you have the right to have friends or family present. 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 SNBC [*insert either:* care coordinator or case manager] will send you [*insert if applicable*: 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.]  [*If applicable, plans should insert additional information about their process*]  If you’re currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, your county case manager will coordinate home health agency services with your SNBC [*insert either* 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 Relocation Service Coordination.] |  |
|  | Home health agency care  [*Plans should modify this section to reflect Medicaid or plan-covered supplemental 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. You must be homebound, which means leaving home is a major effort.  We 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) * [*MSHO insert*: personal care assistant (PCA) services and Community First Services and Supports (CFSS).] | [*List copays*.] |
|  | Home infusion therapy  We 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.   We cover home infusion services that include but aren’t limited to:   * professional services, including nursing services, provided in accordance with your care plan; * member training and education not already included in the DME benefit; * remote monitoring; **and** * monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.   [*List any additional benefits offered*.] | [*List copays*.]  [*List copays for additional benefits*.] |
|  | Hospice care  You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan’s service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.  Covered services include:   * drugs to treat symptoms and pain * short-term respite care * home care   **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:**   * Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you’re in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for.   **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:**   * We cover services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay [*insert as appropriate:* our plan’s cost-sharing amount***or*** nothing] for these services.   **For drugs that may be covered by our plan’s Medicare Part D benefit:**   * Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Member Handbook*.   **This benefit is continued on the next page** | [*List copays*.]  [*Include information about cost-sharing for hospice consultation services if applicable*.] |
|  | Hospice care (continued)  **Note:** If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that **isn’t** related to your terminal prognosis.  [*Insert if applicable*, *edit as appropriate*: We cover hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.] |  |
|  | Housing stabilization services  We 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 transition- moving expenses up to $3000 per year for people leaving a Medical Assistance funded institution or provider-controlled setting who are moving into their own home. Moving expenses include: * applications, security deposits, and the cost of securing documentation that’s required to get a lease on an apartment or home * essential household furnishings including furniture, window coverings, food preparation items, and bed/bath linens * set up fees or deposits for utilities including telephone, electricity, heating and water * services necessary for the individual’s health and safety such as pest removal and one time cleaning beforemoving in * necessary home accessiblility adaptations * Housing sustaining services to help you keep your housing * Transportation for Housing Stabilization Services when a proivder is discussing housing-related need with the member while driving. This time is billed as transition/sustaining units. Mileage isn’t reimbursed.   This benefit is continued on the next page |  |
|  | Housing stabilization services (continued)  You must have an assessment done to find out if you qualify for Housing Stabilization Services.  If you have a targeted case manager or waiver case manager or senior care coordinator, you can ask for their help to find out if you qualify for Housing Stabilization Services. You can also contact a Housing Stabilization Services provider to help you.  Department of Human Services (DHS) staff will review the assessment to decide whether you qualify for Housing Stabilization Services. DHS will send you a letter about whether you qualify for Housing Stabilization Services. If you qualify, the letter will say services are approved. If you don’t qualify, the letter will say services are denied.  Work with you provider if you need help with moving expenses. If you’re approved for moving expenses, your provider must send us the receipt for each moving expense. |  |
| Apple icon indicates preventive services. | Immunizations  We pay for the following services:   * pneumonia vaccines * flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary * hepatitis B vaccines if you’re at high or intermediate risk of getting hepatitis B * COVID-19 vaccines * other vaccines if you’re at risk and they meet Medicare Part B coverage rules   We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Member Handbook* to learn more.  [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | Inpatient hospital care  Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you’re formally admitted to the hospital with a doctor’s order. The day before you’re discharged is your last inpatient day.  [*List any restrictions that apply*.]  We pay for the following services and other medically necessary services not listed here:   * semi-private room (or a private room if 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 abuse services * in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, 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 our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. |
|  | Inpatient hospital care (continued)  If you need a transplant, a Medicare-approved transplant center will review your case and decide if you’re 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 our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.] [*Plans may further define the specifics of transplant travel coverage*.]   * blood, including storage and administration * physician services   **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you’re not sure if you’re an inpatient or an outpatient, ask the hospital staff.  Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at [Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. |  |
|  | Inpatient services in a psychiatric hospital  We pay for mental health care services that require a hospital stay including extended inpatient psychiatric hospital stays. [*List days covered, restrictions such as 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit doesn’t apply to inpatient mental health services provided in a psychiatric unit of a general hospital*.]  [*List any additional benefits offered*.] | $0 |
|  | [*Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate*.]  Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay  We don’t pay for your inpatient stay if you’ve used all of your inpatient benefit or if the stay isn’t reasonable and medically necessary.  However, in certain situations where inpatient care isn’t covered, we may pay for services you get while you’re in a hospital or nursing facility. To find out more, contact Member Services.  We pay for the following services, and maybe other services not listed here:   * doctor services * diagnostic tests, like lab tests * X-ray, radium, and isotope therapy, including technician materials and services * surgical dressings * splints, casts, and other devices used for fractures and dislocations * prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: * an internal body organ (including contiguous tissue), **or** * the function of an inoperative or malfunctioning internal body organ. * leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition * physical therapy, speech therapy, and occupational therapy | $0 |
|  | Interpreter services  The plan will pay for the following services:   * spoken language interpreter services * sign language interpreter services |  |
|  | Kidney disease services and supplies  We pay for the following services:   * Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We 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** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. * Inpatient dialysis treatments if you’re 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.   Medicare Part B pays for some drugs for dialysis. For information, refer to “Medicare Part B drugs” in this chart. | $0 |
| Apple icon indicates preventive services. | Lung cancer screening with low dose computed tomography (LDCT)  We pay for lung cancer screening every 12 months if you:   * are aged 50-77, **and** * have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** * have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years   After the first screening, we pay for another screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.  [*Modify section to accurately describe benefits and list any additional benefits offered*.] | $0 |
|  | Medical Assistance covered drugs  We’ll cover some drugs under Medical Assistance that aren’t 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 *List of Covered Drugs* (*Drug List*). We’ll cover a a drug not on the *Drug List* if your doctor shows us that:   * the drug that’s normally covered has caused a harmful reaction to you; or * there’s a reason to believe the drug that’s normally covered would cause a harmful reaction; or * the drug prescribed by your doctor is more effective for you than the drug that’s normally covered.   The drug must be in a class of drugs that’s covered.  If pharmacy staff tells you the drug isn’t covered and asks you to pay, ask them to call your doctor. We can’t pay you back if you pay for it. There may be another drug that’ll work that’s 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. |  |
| Apple icon indicates preventive services. | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It’s also for after a kidney transplant when [*insert as appropriate*: referred ***or*** ordered] by your doctor.  We pay for three hours of one-on-one counseling services during thefirst year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.  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 you need treatment in the next calendar year. We may approve additional services if medically necessary.  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)  We pay for MDPP services for eligible people. 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 drugs  [*Plans that do or expect to use Medicare Part B step therapy should indicate the Medicare Part B drug categories below that are or may be subject to Medicare Part B step therapy as well as a link to a list of drugs subject to Medicare Part B step therapy. Plans may update the link throughout the year and add any changes at least 30 days prior to implementation per 42 CFR 422.111(d).*]  These drugs are covered under Part B of Medicare. We pay for the following drugs:   * drugs you don’t usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services * insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) * other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized * the Alzheimer’s drug Leqembi® (generic lecanemab) which is given intravenously (IV) * clotting factors you give yourself by injection if you have hemophilia * transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn’t cover them * osteoporosis drugs that are injected. We pay for these drugs if you’re homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can’t inject the drug yourself   **This benefit is continued on the next page** | $0 |
|  | **Medicare Part B prescription drugs (continued)**   * some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision * certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does * oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug * certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B * calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar * certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics * erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions [*plans may delete any of the following drugs that they don’t cover*] (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) * IV immune globulin for the home treatment of primary immune deficiency diseases   **This benefit is continued on the next page** |  |
|  | **Medicare Part B drugs (continued)**   * parenteral and enteral nutrition (IV and tube feeding)   [*Insert if applicable*: The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: <URL>.]  We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit.  **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered.  **Chapter 6** of this *Member Handbook* explains what you pay for your 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 services in a psychiatric hospital * outpatient mental health care * partial hospitalization services and Intensive outpatient services |  |
|  | [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate or eliminate this section if not covered*.]  Nursing facility care  We are responsible for paying a total of [*MSHO insert:* 180 days; *SNBC insert:* 100 days] of nursing home room and board. This includes custodial care. If you need continued nursing home care beyond the [*MSHO insert* 180 days; *SNBC insert:* 100 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 our 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 our plan provides  A nursing facility (NF) is a place that provides care for people who can’t get care at home but who don’t need to be in a hospital.  Services that we pay for include, but are not limited to, the following:   * semiprivate room (or a private room if medically necessary) * meals, including special diets * nursing services * physical therapy, occupational therapy, and speech therapy * respiratory therapy * drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) * blood, including storage and administration * medical and surgical supplies usually given by nursing facilities   **This benefit is continued on the next page** | [*List copays*.] |
|  | Nursing facility care (continued)   * lab tests usually given by nursing facilities * X-rays and other radiology services usually given by nursing facilities * use of appliances, such as wheelchairs usually given by nursing facilities * physician/practitioner services * durable medical equipment * dental services, including dentures * vision benefits * hearing exams * chiropractic care * podiatry services   You 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 facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). * a nursing facility where your spouse or domestic partner is living at the time you leave the hospital. |  |
| Apple icon indicates preventive services. | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, we 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*.] |
|  | Obstetrics and Gynecology (OB/GYN) Services  Covered Services:   * prenatal, delivery, and postpartum care * childbirth classes * HIV counseling and testing for pregnant people– open access service * treatment for HIV-positive pregnant people * testing and treatment of sexually transmitted diseases (STDs) – open access service * pregnancy-related services received in connection with an abortion (doesn’t include abortion-related services) * doula services by a certified doula * services provided by a licensed health professional at licensed birth centers, including services of certified nurse midwives and licensed traditional midwives   Not Covered Services:   * Abortion: This service isn’t covered under the Plan. It may be covered by the State. Call DHS Health Care Consumer Support (HCCS) at 651-297-3862 or 800-657-3672 or 711 (TTY) or use your preferred relay service for coverage information. * Planned home births   You have “direct access” to OB-GYN providers [*Insert if applicable*: without a referral] for the following services: annual preventive health exam, including follow-up exams that your <doctor/qualified health care provider> says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as open access, you can go to any <doctor/qualified health care provider> clinic, hospital, pharmacy, or family planning agency. |  |
|  | Opioid treatment program (OTP) services  We pay for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services:   * intake activities * periodic assessments * medications approved by the FDA and, if applicable, managing and giving you these medications * substance use counseling * individual and group therapy * testing for drugs or chemicals in your body (toxicology testing)   [*List any other medically necessary treatment or additional benefits offered, with the exception of meals and transportation*.] | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  We pay for the following services and other medically necessary 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, including storage and administration * diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition * other outpatient diagnostic tests   [*Plans can include other covered tests as appropriate*.] | $0 |
|  | Outpatient hospital observation  We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged.  The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.  Note: Unles the provider has written an order to admit you as an inpatient to the hospital, you’re an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren’t sure if you’re an outpatient, ask hospital staff.  Get more information in the Medicare fact sheet *Medicare Hospital Benefts.* This fact sheet is available at [Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) |  |
|  | Outpatient hospital services  We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:   * 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 “inpatient.” * Sometimes you can be in the hospital overnight and still be “outpatient.” * You can get more information about being inpatient or outpatient in this fact sheet: [es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf.](https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.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 Medicaid or plan-covered supplemental benefits as appropriate*.]  Outpatient mental health care  We will pay for the following services, and maybe other services not listed here:   * Certified Community Behavioral Health Clinic (CCBHC) * [*SNBC insert:* Children’s Intensive Behavioral Health Services (CIBHS) (for members under age 21)] * 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 * Dialectical Behavioral Therapy (DBT) Intensive Outpatient Program ( IOP) * Forensic Assertive Community Treatment (FACT) * Mental Health provider travel time * Mental Health Targeted Case Management (MH-TCM) * Outpatient mental health services, including explanation of findings, [*SNBC insert* Family psychoeducation services (for members under age 21)], mental health medication management, neuropsychological services, psychotherapy (patient and/or family, family, crisis and group), and psychological testing   **This benefit is continued on the next page** | $0  [*List copays for additional benefits*.] |
|  | Outpatient mental health care (continued)   * 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), [*SNBC Insert*: Certified family peer specialists. (for members under age 21)],Certified Peer Specialist (CPS) support services in limited situations, [*SNBC insert:* Certified family peer specialists. (for members under age 21)], [*SNBC insert:* Children’s mental health residential treatment services (for members under age 21)], [*SNBC insert*: Children’s Therapeutic Services and Supports (CTSS) including Children’s Day Treatment (for members under age 21),] [*SNBC insert:* Family psychoeducation services (for members under age 21)],Intensive Residential Treatment Services (IRTS), [*SNBC insert*: Intensive Treatment Foster Care Services (for members under age 21)],and [*SNBC insert*: Youth Assertive Community Treatment (Youth ACT) intensive non-residential rehabilitative mental health services (for members ages 18 through 20)], Partial Hospitalization Program (PHP) * [*SNBC insert*: Psychiatric Residential Treatment Facility (PRTF) (for members ages 18 through 20)] * Telehealth   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 isn’t in the plan network. We’ll 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.  **This benefit is continued on the next page** |  |
|  | **Outpatient mental health care (continued)**  We won’t determine medical necessity for court-ordered mental health services. Use a plan network provider for your court-ordered mental health assessment.  The following services aren’t covered under the plan but may be available through your county. Call your county for information.   * Treatment at Rule 36 facilities that aren’t licensed as Intensive Residential Treatment Services (IRTS) * Room and board associated with Intensive Residential Treatment Services (IRTS) * [*SNBC insert*: Treatment and room and board services at certain children’s residential mental health treatment facilities in bordering states]   [*List any additional benefits offered*.] |  |
|  | [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate*.]  Outpatient rehabilitation services  We 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 substance use disorder services  We pay for the following services, and maybe other services not listed here:   * screening/Assessment/Diagnosis including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services * outpatient treatment * outpatient medication assisted treatment * substance use disorder treatment coordination * peer recovery support * detoxification (only when inpatient hospitalization is medically necessary because of conditions resulting from injury or accident or medical complications during detoxification) * withdrawal management   A qualified professional who is part of our network will make recommendations for substance use disorder services for you. You may elect up to the highest level of care recommended by the qualified professional. You may receive an additional assessment at any point throughout your care, if you don’t agree with the recommended services. If you agree with the second assessment, you may access 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*].  [*Modify this list accurately describe benefits offered or add any additional benefits offered*.] | [*List copays*.] |
|  | Outpatient surgery  We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.  **Note:** If you’re having surgery in a hospital facility, you should check with your provider about whether you’ll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you’re an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. | $0 |
|  | [*Plans should modify this section to reflect Medicaid or plan-covered supplemental benefits as appropriate*.]  Partial hospitalization services and intensive outpatient services  **Partial hospitalization** is a structured program of active psychiatric treatment. It’s offered as a hospital outpatient service or by a community mental health center that’s more intense than the care you get in your doctor’s, therapist’s, licensed marriage and family therapist’s (LMFT), or licensed professional counselor’s office. It can help keep you from having to stay in the hospital.  **Intensive outpatient service** is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that’s more intense than care you get in your doctor’s, therapist’s, LMFT, or licensed professional counselor’s office but less intense than partial hospitalization.  [*Plans that don’t have an in-network community mental health center can 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  We pay for the following services:   * medically necessary health care or surgery services given in places such as: * physician’s office * certified ambulatory surgical center * hospital outpatient department * consultation, diagnosis, and treatment by a specialist * basic hearing and balance exams given by your [*insert as applicable*: primary care provider ***or*** specialist], if your 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 isn’t in the same location as the member). Plans may refer members to its medical coverage policy here*].   **This benefit is continued on the next page** | $0  [*List copays for additional benefits*.] |
|  | Physician/provider services, including doctor’s office visits (continued)   * 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.*]] * [*Insert if the plan’s service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act:* Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare] * telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at 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   **This benefit is continued on the next page** |  |
|  | Physician/provider services, including doctor’s office visits (continued)   * telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:   + You have an in-person visit within 6 months prior to your first telehealth visit   + You have an in-person visit every 12 months while receiving these telehealth services   + Exceptions can be made to the above for certain circumstances * telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. * 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 * 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   This benefit is continued on the next page |  |
|  | Physician/provider services, including doctor’s office visits (continued)   * 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 * Preventive and physical exams * Family Planning services. For more information, refer to the “Family planning” section of this chart * Out-of-network services related to the diagnosis, monitoring and treatment of a rare disease or condition   [*List any additional benefits offered*.] |  |
|  | Podiatry services  We pay for the following services:   * diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) * routine foot care for members with conditions affecting the legs, such as diabetes * 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. | Pre-exposure prophylaxis (PrEP) for HIV prevention  If you don’t have HIV, but your doctor or other health care practitioner determines you’re at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.  If you qualify, covered services include:   * FDA-approved oral or injectable PrEP medication. If you’re getting an injectable drug, we also cover the fee for injecting the drug. * Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. * Up to 8 HIV screenings every 12 months. * A one-time hepatitis B virus screening. |  |
| Apple icon indicates preventive services. | Prostate cancer screening exams  [*Plans that cover men under age 65 must include*:For men aged 50 and over,] we 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 Medcaid or plan-covered supplemental benefits as appropriate*.]  Prosthetic and orthotic devices and related supplies  Prosthetic devices replace all or part of a body part or function. These include but aren’t limited to:   * testing, fitting, or training in the use of prosthetic and orthotic devices * colostomy bags and supplies related to colostomy care * pacemakers * braces * prosthetic shoes * artificial arms and legs * breast prostheses (including a surgical brassiere after a mastectomy) * wigs for people with hair loss due to any medical condition * some shoes when a part of a leg brace or when custom molded   We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices.  We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details. | $0 |
|  | Pulmonary rehabilitation services  We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You 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*.] |
|  | Recuperative care  Recuperative care helps qualified members avoid being readmitted to the hospital.  It provides short-term lodging, medical care and support for up to sixty (60) days for those who are recovering from an illness and are unhoused. This care is for members who need help to recover, but don't need to stay in the hospital.  We pay for the following services:   * basic nursing care, like checking health and pain * wound care * help with taking medicine * teaching about health * checking and updating shots (immunizations) * planning for recovery and going home * checking and planning for medical, emotional, and social needs * creating and following a care plan * helping with legal issues, finding a place to live, getting rides, and other community services * helping with health care and other benefits * following up on care plans * providing medical, social, and emotional support, like counseling * community health worker services   We don’t pay for the following services:   * services related to a member’s emotional health needs that exceed those a provider can support   **This benefit is continued on the next page** | $0  [*List copays for additional benefits*.] |
|  | Recuperative care (continued)   * services related to Activities of Daily Living (ADL) that a member can’t perform on their own, such as standing up or using the bathroom * payment for room and board associated with recuperative care services is the responsibility of the Minnesota Department of Human Services |  |
| Apple icon indicates preventive services. | Screening for Hepatitis C virus infection  We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:   * You’re at high risk because you use or have used illicit injection drugs. * You had a blood transfusion before 1992. * You were born between 1945-1965.   If you were born between 1945-1965 and aren’t considered high risk, we pay for a screening once. If you’re at high risk (for example, you’ve continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings. |  |
| Apple icon indicates preventive services. | Sexually transmitted infections (STIs) screening and counseling  We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered [*plans that cover women under age 65 should include*: for pregnant women and] for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.  We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor’s office.  [*Also 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.  For a definition of skilled nursing facility care, go to **Chapter 12.**  We 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 * skilled 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 * medical and surgical supplies given by SNFs * lab tests given by SNFs * 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 usually get SNF care from network facilities. Under certain conditions 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 facility 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 (counseling to stop smoking or tobacco use)  Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:   * use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease * are comepent and alert during counseling * a qualified physician or other Medicare-recognized practitioner provides counseling   We pay for two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).  We pay for the following services:   * In-Person Counseling: You can get help with quitting tobacco or nicotine through individual or group sessions led by trained health care practitioners. * Telephone Counseling: You can call <MCO Quitline> for support. This service can be accessed by phone and does not require video. [*MCOs may include additional description for their Quitline service*] * <Quitline phone number> * *<*hours*>* * <email> * <URL> * Medications: You can get both prescription and over-the-counter medications approved by the FDA to help you quit smoking or using nicotine. * Telemedicine: Services can also be provided through telemedicine. (video calls or online)   **This benefit is continued on the next page** | $0  [*List copays for supplemental benefits*.] |
|  | Smoking and tobacco use cessation (continued)   * No Limits: There are no limits on how often you can use these services or how many times you can receive counseling or medications for tobacco and nicotine cessation services. * Multiple Services: You can use different types of support at the same time, like counseling and medications.   [*List any additional benefits offered*.] |  |
|  | Supervised exercise therapy (SET)  We 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].  Our plan pays 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 <phone number>. We’ll provide the most appropriate and cost-effective transportation. Our plan isn’t required to provide transportation to your Primary Care Clinic if it’s over 30 miles from your home or if you choose a specialty provider that’s more than 60 miles from your home. Call <phone number> if you don’t have a Primary Care Clinic that’s available within 30 miles of your home and/or you don’t have a specialty provider that’s 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 doesn’t cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking, also including out of state travel. These services aren’t 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 aren’t allowed to include information regarding a penalty for missed rides.*] |  |
|  | Urgently needed care  Urgently needed care is care given to treat:   * a non-emergency that requires immediate medical care, **or** * an unforseen 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 can’t get to a network provider beause given your time, place, or circumstances, it’s not possible, or it’s unreasonable to get this service from network providers (for example, when you’re outside the plan’s service area and you require medically needed immediate services for an unseen condition but it’s not a medical emergency).  [*Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage*.]  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 Medicaid and plan-covered supplemental benefits as appropriate. Add the apple icon if listing only preventive services*.]  Vision care  We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration.  For people at high risk of glaucoma, we 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 [*plans that cover under 65 must include*: who are 50 and over] * Hispanic Americans [*plans that cover under 65 must include*: who are 65 or over]   For people with diabetes, we pay for screening for diabetic retinopathy once per year.  [*Plans should modify this description if the plan offers more than is covered by Medicare.*] We 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 can’t get two pairs of glasses after the second surgery, even if you didn’t get a pair of glasses after the first surgery.  We also cover the following:   * eye exams * initial eyeglasses, when medically necessary. (eyeglass frame selection may be limited).   **This benefit is continued on the next page** | [*List copays*.]  [*List copays for additional benefits*.] |
|  | **Vision care (continued)**   * 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 * tinted, 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 doesn’t cover an extra pair of glasses, progressive bifocal/trifocal lenses (without lines), protective coating for plastic lenses, and contact lens supplies.] |  |
| Apple icon indicates preventive services. | “Welcome to Medicare” preventive visit  We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:   * a review of your health, * education and counseling about 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 |

# Extra “Optional Supplemental” benefits you can buy

[*Include this section if you offer optional supplemental benefits in the plan and describe benefits below. Plans must explain how these benefits are different than what’s covered under Medicaid. You may include this section either in the Member Handbook or as an insert to the Member Handbook*.]

Our plan offers some extra benefits that aren’t covered by Original Medicare and not included in your benefits package. These extra benefits are called “**Optional Supplemental Benefits**.” If you want these optional supplemental benefits, you must sign up for them [*insert if applicable*: and you may have to pay an additional premium for them.] The optional supplemental benefits described in [*insert as applicable*: this section *OR* the enclosed insert] are subject to the same appeals process as any other benefits.

[*Insert plan specific optional supplemental benefits, premiums, deductible, copays, and coinsurance and rules using a chart like the Benefits Chart above. Insert plan specific procedures on how to elect optional supplemental coverage, including application process and effective dates and on how to discontinue optional supplemental coverage, including refund of premiums. Also, insert any restrictions on members’ re-applying for optional supplemental coverage (e.g., must wait until next open enrollment period*).]

# 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 about getting the out-of-area coverage, including the impact based on Medicaid requirements. 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’re out of the plan’s service area for more than 6 months at a time but don’t permanently move, we usually must disenroll you from our plan. However, we offer a visitor/traveler program [*specify areas where the visitor/traveler program is being offered*] that allows you to stay enrolled in our plan when you’re outside of our service area for up to 12 months. Under our visitor/traveler program, you get all plan-covered services at in-network cost-sharing prices. Contact us for help in finding a provider when you use the visitor/traveler benefit.

If you’re in a visitor/traveler area, you can stay enrolled in the plan until <end date>. If you don’t return to our plan’s service area by <end date>, we’ll end your membership in our plan.]

# Benefits covered outside of our plan

[*Plans should modify this section to include additional benefits covered outside the plan by Medicaid fee-for-service and/or a Medicaid managed care plan, as appropriate*.]

We don’t cover the following services, but they’re available through Medicare or Medical Assistance.

## G1. Other Services

The following services aren’t 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 DHS Health Care Consumer Support (HCCS) at 651-297-3862 or 1-800-657-3672 or 711 (TTY) or use your preferred relay service. This call is free.

[*Plans may alphabetize lists for MSHO and SNBC*]

* Case management for people with developmental disabilities
* [*SNBC Insert*: Child welfare targeted case management]
* [*SNBC Insert*: Consumer Support Grant (CG)]
* [*SNBC Insert*: HIV services under the Ryan White Act]
* [*SNBC Insert*: Home Care Nursing]
* [*SNBC Insert*: Personal Care Assistant (PCA) services/Community First Services and Supports (CFSS)]
* [*SNBC Insert*: Relocation Service Coordination (RSC)]
* [*SNBC Insert*: Waiver services provided under Home and Community- Based Services waivers]
* Intermediate care facility for people who have a developmental disability (ICF/DD)
* Treatment at Rule 36 facilities that aren’t 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
* [*MSHO Insert:* 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 isn’t otherwise responsible. (Refer to the “Nursing facility care” and the “Skilled nursing facility (SNF) care” sections in the Benefits Chart for additional information.)
* Vulnerable Adult Protective Services
* Medical Assistance covered services provided by federally qualified health centers (FQHC)

# Benefits not covered by our plan, Medicare, or Medical Assistance

This section tells you about benefits excluded by our plan. “Excluded” means that we don’t pay for these benefits. Medicare and Medical Assistance don’t pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don’t pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won’t pay for the services. If you think that our plan should pay for a service that isn’t covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn’t cover the following items and services:

[*The services listed in the remaining bullets are excluded from Medicare’s and Medicaid’s benefit packages. If any services below are plan-covered supplemental benefits, are required to be covered by Medicaid 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 can add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans can also add exclusions as needed*.]

* services considered not “reasonable and medically necessary”, according Medicare and Medical Assistance standards, unless we list these as covered services
* experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
* surgical treatment for morbid obesity, except when medically necessary and Medicare or Medical Assistance pays for it
* a private room in a hospital, except when medically necessary
* personal items in your room at a hospital or a nursing facility, such as a telephone or television
* fees charged by your immediate relatives or members of your household
* 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’s needed because of an accidental injury or to improve a part of the body that isn’t shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
* routine foot care, except as described in Podiatry services in the Benefits Chart in Section D
* [*Plans delete this if supplemental*:] radial keratotomy, LASIK surgery, and other low-vision aids
* reversal of sterilization procedures and non-prescription contraceptive supplies
* naturopath services (the use of natural or alternative treatments)
* services provided to veterans in Veterans Affairs (VA) facilities. [*Zero cost-sharing plans can adjust this language as applicable*] 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’ll reimburse the veteran for the difference. You’re still responsible for your cost-sharing amounts.