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 may 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*.]

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# 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 are not 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 are 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 assistance 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 the 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)>].

[*As applicable, plans insert the subsection heading and information below*.]

## A1. During public health emergencies

[*Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.*]

# Rules against providers charging you for services

We 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 may 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 do not have cost-sharing, insert*: You do **not** 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 may 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 is 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 prescription 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 the plan must provide a minimum 90-day transition period, during which time the new Medicare Advantage plan may not require prior authorization 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 receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given 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 that is providing and managing your care. [*Plans that do not require referrals, omit the rest of this paragraph*:] In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3** of this *Member Handbook* has more information about getting a referral and when you do **not** need one.]
* [*Plans may 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 is 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.

[*Instructions to plans offering Value-Based Insurance Design (VBID) Model* *benefits for enrollees with certain chronic conditions:*

* *Plans may deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines*).
* *If applicable, plans must update the Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID benefits*.
* *If applicable, plans with VBID should mention reduced cost-sharing for their MA benefits, as well as that members may qualify for a reduction or elimination of their cost-sharing for Part D drugs in Plans with VBID may include the reduction or elimination of their cost-sharing for Part D drugs in* ***Chapter 6, Section C***.]

[*Insert if offering VBID Model benefits*:

Important Benefit Information for Enrollees with Certain Chronic Conditions

* If you are diagnosed by a plan provider with any of the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for targeted supplemental benefits and/or reduced cost-sharing:
  + [*List all applicable chronic conditions here*.]
  + [*As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high-value provider, include those limitations and then direct the enrollee that they will be provided additional information with how to take advantage of these additional supplemental benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines*).]
* *For further detail, please go to the* ***VBID*** *row in the Benefits Chart below*.]

[*Instructions to plans offering VBID Model benefits for enrollees living in certain geographic areas:*

* *Plans may deliver to each geographically targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines.)*
* *Plans who choose to reduce cost sharing for an item or service, must include a summary of the additional supplemental benefits they would receive as well as the activities and/or programs the member must complete to receive the benefit.*
* *If applicable, plans must update the Medical Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID.*]

[*Insert if offering the following VBID Model benefit:*

* If you live in certain geographic areas identified below, you may be eligible for targeted supplemental benefits and/or reduced cost sharing:
  + [*List all applicable census tracts and blocks groups here (e.g. Census Tract 9800- Block Group 1); organize by county for readability.*
  + [*Insert a phone number for enrollees to call for assistance with identifying eligibility and determining the enrollee’s Census Tract and Block Group, include the plan web address for more information on supplemental benefits.*]
  + [*As applicable, plans may enter an explanation of how enrollees can identify the census tract and block group they live in. For example, plans may provide the link and instructions/video on how to locate your own census track and block by entering their address in* [*www.geocoding.geo.census.gov/geocoder/geographies/address?form*](https://geocoding.geo.census.gov/geocoder/geographies/address?form)*.*]
  + [*As applicable, plans offering benefits under VBID that require participation in a health and wellness program or to see a high-value provider, include those limitations and instruct the enrollee they will be provided additional information on how to take advantage of these additional supplemental benefits (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).*]
* For further detail, please go to the **VBID** row in the Benefits Chart below.]

[*List the areas within the PBP that are eligible for the benefits below or describe how the enrollee can inquire about or will receive additional information about the benefit.*

[*Instructions to plans offering VBID benefits for LIS- targeted enrollees*:]

* *Plans may deliver to each LIS-targeted enrollee a written summary of those benefits so that such enrollees are notified of VBID benefits for which they are eligible. For VBID plans that choose to deliver a written notice, VBID plans must follow the VBID guidance on communications for delivering such a written notice when offering targeted supplemental or VBID benefits. (See CY 2025 Value-Based Insurance Design Communications and Marketing Guidelines).*
* *Plans who choose to reduce cost-sharing for an item or service, including Part D drugs covered by Medicare Advantage Prescription Drug (MA-PD) plan through member participation in a plan-sponsored disease management or similar program, must include a summary of the additional supplemental benefits they would receive as well as the activities and/or programs the member must complete in order to receive the benefit.*
* *If applicable, plans must update the Benefits Chart and include a supplemental benefits chart including a column that details the exact targeted reduced cost-sharing amount for each specific service, and/or the additional supplemental benefits being offered. Specific services should include details as it relates to VBID benefits*.
* *If applicable, plans with VBID should mention that members may qualify for a reduction or elimination of their cost-sharing for Part D drugs in* ***Chapter 6, Section C***.

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

* If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits [insert if applicable: and/or reduced cost-sharing]:
  + [*List all applicable chronic conditions here*.]
  + [*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.]
* Please contact us for additional information.

[*Insert as applicable*: Most ***or*** All] preventive services are free. You will find this apple Apple icon represents preventive services in the benefits chart. next to preventive services in the Benefits Chart.

[*Insert any additional applicable Medicaid program coverage here such as community supports. Minnesota Plans insert the following:*

Restricted Recipient Program

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

[*Instructions on completing the Benefits Chart:*

* *For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.*
* *Optional supplemental benefits are not 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 may 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 may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.*
* *Plans 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 are eligible.*
* *Update the Benefits Chart to include details, as applicable, about the exact targeted reduced cost-sharing amount for each specific service and/or the additional supplemental benefits being offered*.]

# 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 or plan-covered supplemental benefits as appropriate as well as any copays that may differ for Medicaid*.]

| Services that our plan pays for | | What you must pay |
| --- | --- | --- |
| Apple indicates preventive benefit. | Abdominal aortic aneurysm screening  We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.  We may cover additional screenings if medically necessary.  [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
|  | Acupuncture  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 will 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 * menstrual disorders   **This benefit is continued on the next page** | $0  [*List copays for additional benefits*.] |
|  | Acupuncture (continued)   * 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   [*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 are not 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 are 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-emergent 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-emergent) must be approved by us. In cases that are not 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 age 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 are eating well.   [*List any additional benefits offered*.] | $0  [*List copays for additional benefits*.] |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease testing  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:* The plan pays for care coordination services, including the following:   * Assisting you in arranging for, getting, and coordinating assessments, tests, and health and long-term care supports and services * Working with you to develop and update your care plan * Supporting you and communicating with a variety of agencies and persons * Coordinating other services as outlined in your care plan]   [*List any additional benefits offered.*]  [*SNBC Insert:* You are 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 would 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 are offered county case management and do not want to work with a county case manager, you can ask for a <Plan name> care coordinator to work with you instead.]  Covered 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, <Plan name> 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, <Plan name> 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 visits provide children, teens and young adults with regular age-appropriate preventive, dental, mental health, developmental and , when needed, specialty services.  Depending on age these visits may include:   * growth measurements * health education * health history including nutrition * developmental Screening * social-emotional or mental health screening * head-to-toe physical exam * immunizations * lab tests * vision checks * hearing checks * oral health, including fluoride varnish application   C&TC is a health care program of well-child visits for members under age 21.  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&TC well-child and preventive health visits. |  |
|  | Chiropractic services  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   Note: Our plan does not 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*.] |
| 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 are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. * Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received 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 pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. * Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. * Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.   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*.] | $0  [*List copays for additional benefits*.] |
|  | [*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.  Covered Services:  Diagnostic services:   * comprehensive exam [(once per five years)] [(cannot be performed on same date as a periodic or limited evaluation)] * periodic exam [(once per calendar year)] [(cannot be performed on same date as a limited or comprehensive evaluation)] * limited (problem-focused) exams [(once per day)] [(cannot be performed on same date as a periodic or comprehensive oral evaluation, [or dental cleaning service]] * detailed oral evaluation [(cannot be performed on same date as full mouth debridement)] * periodontal evaluation [(cannot be performed on same date as full mouth debridement)] * teledentistry for diagnostic services ‘ * imaging services, limited to: * bitewing (once per calendar year) * single X-rays for diagnosis of problems [(four per date of service)] * panoramic [(once every five years and as medically necessary; once every two years in limited situations; or with a scheduled outpatient hospital facility or freestanding Ambulatory Surgery Center (ASC) procedure.)] * full mouth X-rays [(once every five years)]   **This benefit is continued on the next page** | [*If plan offers supplemental benefit, the maximum copay amount is $10*.] |
|  | **Dental Services (Continued)**  Preventive services:   * dental cleaning[s] [(limited to two per calendar year)] [(up to four times per year if medically necessary [with <Service/Prior> Authorization) * fluoride varnish (once every six months) [(cannot be performed on the same date as emergency treatment of dental pain service)] * sealants [(one every five years per permanent molar)] * cavity treatment [(once per tooth per 6 months)] * oral hygiene instruction [(<Service/Prior> Authorization is required for additional service)]   Restorative services:   * fillings [(limited to once per 90 days per tooth)] * sedative fillings for relief of pain [(cannot be performed on same date as emergency treatment of dental pain service)] * individual crowns [(must be made of prefabricated stainless steel or resin)] [(with <Service/Prior> Authorization)]   Endodontics (root canals) [( once per tooth per lifetime)]  Oral surgery  Orthodontics (only when medically necessary for very limited conditions) [(with <Service/Prior> Authorization )]  Periodontics:   * gross removal of plaque and tartar (full mouth debridement) [(once per five years) (cannot be performed on same date as dental cleaning service, comprehensive exam, oral evaluation or periodontal evaluation service)]   This benefit is continued on the next page |  |
|  | **Dental Services (Continued)**   * scaling and root planing [(with <Service/Prior> Authorization)] [(cannot be performed on same day as dental cleaning or full mouth debridement) (once every two years for each quadrant)] * Follow-up procedures (periodontal maintenance) [(with <Service/Prior>authorization)] [(every three months/91 days for two years)] [(up to four per calendar year following the completion of scaling and root planing)]   Prosthodontics:   * removable appliances (dentures and partials) [(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) [(repairs to missing or broken teeth are limited to five teeth per180 days)] * replacement of appliances that are lost, stolen, or damaged beyond repair under certain circumstances [(with <Service/Prior> Authorization)] * replacement of partial appliances if the existing partial cannot be altered to meet dental needs [(with <Service/Prior> Authorization)] * tissue conditioning liners * precision attachments and repairs   Additional general dental services:   * emergency treatment of dental pain [(once per day)] * general anesthesia, deep sedation * [General anesthesia may be covered in a clinic setting under certain circumstances. If optional language is added, include a list of circumstances in this sub-bullet.]   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) [(cannot be performed on same date as oral hygiene instruction service)] * 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 [(only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)] * oral bite adjustments [(complete adjustments with <Service/Prior> Authorization)] [(limited to once per day)] * Oral or IV sedation (only if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center)   Notes:  If you choose to get dental benefits from a Federally Qualified Health Center (FQHC) or a state-operated dental clinic, you will have the same benefits that you are entitled to under Medical Assistance.  If you are 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 will not 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 beneficiary’s primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.  [*Plans that offer optional supplemental dental benefits at an additional cost insert*: Note: Our plan offers additional dental services. Go to 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 are 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 will not 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 do not limit the DME brands and manufacturers that they cover, insert*:We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.]  [*Plans that limit the DME brands and manufacturers that 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 may 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 Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, 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 are 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 may 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 right for your medical condition. For more information about appeals, refer to Chapter 9 of this *Member Handbook*.] |  |
|  | [*Insert for SNBC:* Early Intensive Developmental and behavioral Intervention (EIDBI) Servcies (for member 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 [EIDBI 101](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/) [(<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)   [(https://www.dhs.state.mn.us/EIDBI-TreatmentModalities)]  **This benefit is continued on the next page** |  |
|  | 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. [(https://www.dhs.state.mn.us/CMDE)] * Individual Treatment Plan (ITP) Development (Initial) * ITP Development and Progress Monitoring   [([www.dhs.state.mn.us/ITP](https://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   [(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](https://www.dhs.state.mn.us/EIDBI-CaregiverTrainingandCounseling))]   * Coordinated Care Conference   [(<https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_195209>)]   * Travel time |  |
|  | [*MSHO Insert:* 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: Management of your health and long-term care services among different health and social service professionals. * Chore Services: Heavy household services needed to keep your home clean and safe. * Consumer Directed Community Support Services: Services that you design to meet your needs and manage yourself within a set budget. * Customized Living/24-Hour Customized Living: A group of individualized services (health related and supported services) provided in a qualified setting. * Environmental Accessibility Adaptations (EAA): Home modification assessment and home modification installation and vehicle modification assessment and vehicle modification installation. * Extended State Plan Home Health Care Services: This includes home health aide and nursing services that are over the Medical Assistance limit. * Extended State Plan Home Care Nursing: This includes home care 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 Personal Care Assistance (PCA) Services (Community First Services and Supports (CFSS) will replace PCA services at the member’s annual assessment starting October1, 2024).Help with personal care and activities of daily living (ADLs) over the Medical Assistance limit. Direct support workers an also assist with covered instrumental activities of daily living (IALDs) * Family and 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 cannot 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 are not a part of other Medical Assistance coverage but are specified in your support plan. This includes the Personal Emergency Response System (PERS) * Transitional Services: Items and supports necessary to move from a licensed setting to an independent or semi-independent community-based housing. * Transportation (non-medical): Enables you to gain access to activities and services in the community.   This benefit is continued on the next page |  |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)  You must have a MnCHOICES assessment, formerly called a Long-Term Care Consultation (LTCC) done and be found to be nursing home level of care to get these Elderly Waiver (EW) services. You can ask to have this assessment in your home, apartment, or facility where you live.  Your MSHO [*insert*: care coordinator *or* case manager] will meet with you and your family to talk about your care needs within 20 days if you call to ask for a visit.  Your MSHO [*insert:* care coordinator *or* case manager] will give you information about community services, help you find services to stay in your home or community, and help you find services to move out of a nursing home or other facility.  You have the right to have friends or family present at the visit. You can designate a representative to help you make decisions. You can decide what your needs are and where you want to live. You can ask for services to best meet your needs. You can make the final decisions about your plan for services and help. You can choose who you want to provide the services and supports from those providers available from our plan’s network.  After the visit, your MSHO [*insert*: care coordinator *or* case manager] will send you a letter that recommends services that best meet your needs. You will be sent a copy of the service or care plan you helped put together. Your MSHO [*insert:* care coordinator *or* case manager] will help you file an appeal if you disagree with suggested services or were informed you may not qualify for these services.  People who live on or near the White Earth, Leech Lake, Red Lake, Mille Lacs, or Fond du Lac Reservations may be able to choose to get their EW services through the Tribal health or human services division or through our plan. Contact the tribal nation or our plan if you have questions.  This benefit is continued on the next page |  |
|  | Elderly Waiver Services (Home and Community-Based Services) (continued)  If you are currently on the Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Brain Injury (BI), or the Developmental Disability (DD) waiver, you will continue to get services covered by these programs in the same way you get them now. Your county case manager will continue to authorize these services and coordinate with your MSHO [insert: care coordinator or case manager].  If you need transition planning and coordination services to help you move to the community, you may be eligible to get Moving Home Minnesota (MHM) services. MHM services are separate from EW services, but you must be eligible for EW.] |  |
|  | Emergency care  Emergency care means services that are:   * given by a provider trained to give emergency services, **and** * needed to treat a medical emergency.   A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:   * serious risk to your health [*Plans that cover women under 65 must include*: or to that of your unborn child]; **or** * serious harm to bodily functions; **or** * serious dysfunction of any bodily organ or part. * [*Plans that cover women under 65 must include*:In the case of a pregnant woman in active labor, when: * There is not 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 return to a network hospital for your care to continue to be paid for.You can stay in the out-of-network hospital for your inpatient care only if 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 (IUC/IUD, implants, injections, birth control pills, patch, or ring) * family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) * counseling and diagnosis of infertility and related services * counseling, testing, and treatment for sexually transmitted infections (STIs) * counseling and testing for HIV and AIDS, and other HIV-related conditions * permanent contraception (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 does not 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 is not applicable, plans should delete this row*.] | [*List copays*.] |
|  | Health services  The plan will pay for the following services:   * Advanced Practice Nurse services: services provided by a nurse practitioner, nurse anesthetist, nurse midwife, or clinical nurse specialist * 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: 1) provided as part of the protocol treatment of a clinical trial; 2) is usual, customary and appropriate to your condition; and 3) 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 * 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.**]** * 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 special equipment to send health data to providers from a remote location, like a member’s home. Providers use telemonitoring to help manage complex health care without the need for the member to be in a clinic or hospital. * 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 are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  We cover additional items and services, including:   * Hearing aids and batteries * Repair and replacement of hearing aids due to normal wear and tear, with limits | [*List copays*.]  [*List copays for additional benefits*.] |
|  | [If this benefit is not applicable, plans should delete this row.]  Help with certain chronic conditions  [*Plans that offer targeted “Uniformity Flexibility” supplemental benefits and/or* “*Special Supplemental Benefits for the Chronically Ill (SSBCI),” which members with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits and (as applicable) reduced cost-sharing. If offering SSBCI, plans must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package 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.   For women who are 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 are 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 supervision of PCA services (Community First Services and Supports (CFSS) will replace PCA services at the member’s annual reassessment starting October 1, 2024).] | [*List copays*.] |
|  | Home infusion therapy  Our plan pays 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.   Our plan covers home infusion services that include but are not limited to:   * professional services, including nursing services, provided in accordance with your care plan; * member training and education not already included in the DME benefit; * remote monitoring; **and** * monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.   [*List any additional benefits offered*.] | [*List copays*.]  [*List copays for additional benefits*.] |
|  | Hospice care  You 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. 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   **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.**   * Refer to **Section F** of this chapter for more information.   **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:**   * Our plan covers 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*.   **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 is **not** related to your terminal prognosis.  [*Insert if applicable*, *edit as appropriate*: Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.] | [*List copays*.]  [*Include information about cost-sharing for hospice consultation services if applicable*.] |
|  | Housing stabilization services  The plan will pay for the following services for members eligible for Housing Stabilization Services:   * Housing consultation services to develop a person-centered plan for people without Medical Assistance case management services * Housing transition services to help you plan for, find, and move into housing * Housing transition- moving expenses (limited to $3000 per year) * Only for people leaving a Medical Assistance funded institution or provider controlled setting that are moving into their own home. * Applications, security deposits, and the cost of securing documentation that is required to obtain a lease on an apartment or home * Essential household furnishings required to live in and use a community-home, including furniture, window coverings, food preparation items, and bed/bath linens * Set up fees or deposits for utility or service access, including telephone, electricity, heating and water * Services necessary for the individual’s health and safety such as pest removal and one time cleaning prior to moving in * Necessary home accessiblility adaptations * Housing sustaining services to help you maintain housing * Transportation to get housing stabilization services (within a 60 mile radius)   Continued on the next page |  |
|  | Housing stabilization services (continued)  You must have a Housing Stabilization Services eligibility assessment done and be found eligible for these services. If you need Housing Stabilization Services, you can ask for an assessment or be supported by your provider or case manager.  If you have a targeted case manager or waiver case manager or senior care coordinator, that case manager can support you in accessing services, or you can contact a Housing Stabilization Services provider directly to help you.  Department of Human Services (DHS) staff will use the results of the assessment to determine whether you meet the needs-based criteria to get this service. DHS will send you a letter of approval or denial for Housing Stabilization Services.  If you are approved for moving expenses, your provider must send us the receipt for each moving expense. Work with your provider on how to access this benefit. |  |
| 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 are at high or intermediate risk of getting hepatitis B * COVID-19 vaccines * other vaccines if you are 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 are formally admitted to the hospital with a doctor’s order. The day before you are 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 are a candidate for a transplant. [*Plans should include the following, modified as appropriate*: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If 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 are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.  You can also find more information in a Medicare fact sheet called “Are you a Hosptial Inpatient or Outpatient? If You Have Medicare – Ask!”. This fact sheet is available on the Web at <https://es.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. You can call these numbers for free, 24 hours a day, 7 days a week. |  |
|  | 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 does not 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 do not pay for your inpatient stay if you have used all of your inpatient benefit or if the stay is not reasonable and medically necessary.  However, in certain situations where inpatient care is not 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.   Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to “Medicare Part B prescription drugs” in this chart. | $0 |
| Apple icon indicates preventive services. | Lung cancer screening  Our plan pays 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, our plan pays for another screening each year with a written order from your doctor or other qualified provider.  [*Modify section to accurately describe benefits and list any additional benefits offered*.] | $0 |
|  | Medical Assistance covered prescription drugs  We will cover some drugs under Medical Assistance that are not covered by Medicare Part B and Medicare Part D. These include some over-the-counter products, some prescription cough and cold medicines and some vitamins.  The drug must be on our covered drug list (formulary). We will cover a non-formulary drug if your doctor shows us that:   * the drug that is normally covered has caused a harmful reaction to you; or * there is a reason to believe the drug that is normally covered would cause a harmful reaction; or * the drug prescribed by your doctor is more effective for you than the drug that is normally covered.   The drug must be in a class of drugs that is covered.  If pharmacy staff tells you the drug is not covered and asks you to pay, ask them to call your doctor. We cannot pay you back if you pay for it. There may be another drug that will work that is covered by our plan. If the pharmacy won’t call your doctor, you can. You can also call Member Services at the number at the bottom of this page. |  |
| Apple icon indicates preventive services. | Medical nutrition therapy  This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [*insert as appropriate*: referred ***or*** ordered] by your doctor.  We pay for three hours of one-on-one counseling services during your first year that 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)  Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:   * long-term dietary change, **and** * increased physical activity, **and** * ways to maintain weight loss and a healthy lifestyle. | $0 |
|  | Medicare Part B prescription drugs  [*Plans that 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. Our plan pays 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 does not cover them * osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot 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 if the same drug is available in injectable form and the Part B ESRD benefit covers it * calcimimetic 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 do not 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 prescription 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: <hyperlink>.]  We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D prescription drug benefit.  **Chapter 5** of this *Member Handbook* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  **Chapter 6** of this *Member Handbook* explains what you pay for your outpatient prescription drugs through our plan. |  |
|  | **Mental health services**  Refer to the following sections for covered mental health services [plans may insert reference, as applicable]:   * Depression screening * Inpatient 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 ourthe plan, will continue to pay for your care.  Refer to the “Skilled nursing facility (SNF) care” section of this chart for more information about the additional nursing home coverage the plan provides  A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not 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 (does not 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 is not 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  Our plan pays for the following services to treat opioid use disorder (OUD):   * 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 * other outpatient diagnostic tests   [*Plans can include other covered tests as appropriate*.] | $0 |
|  | 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: <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 pay for mental health services provided by:   * a state-licensed psychiatrist or doctor * a clinical psychologist * a clinical social worker * a clinical nurse specialist * a licensed professional counselor (LPC) * a licensed marriage and family therapist (LMFT) * a nurse practitioner (NP) * a physician assistant (PA) * a Tribal Nations certified professional * a mental heatlh rehabilitative professional * any other Medicare-qualified mental health care professional as allowed under applicable state laws   The plan will pay for the following services, and maybe other services not listed here:   * Certified Community Behavioral Health Clinic (CCBHC) * [*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   **This benefit is continued on the next page** | $0  [*List copays for additional benefits*.] |
|  | Outpatient mental health care (continued)   * Diagnostic assessments including screening for presence of co-occurring mental illness and substance use disorders * Dialectical Behavioral Therapy (DBT)Intensive Outpatient Program (DBT 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 * Physician Mental Health Services, including health and behavioral assessment/intervention, inpatient visits, psychiatric consultations to primary care providers, and physician consultation, evaluation, and management   **This benefit is continued on the next page** |  |
|  | Outpatient mental health care (continued)   * 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 inser:t* 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 inser:t* 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 is not in the plan network. We will pay for this. We must consider the second opinion, but we have the right to disagree with the second opinion. You have the right to appeal our decision.  We will not determine medical necessity for court-ordered mental health services. Use a plan network provider for your court-ordered mental health assessment.  **This benefit is continued on the next page** |  |
|  | **Outpatient mental health care (continued)**  The following services are not covered under the plan but may be available through your county. Call your county for information.   * Treatment at Rule 36 facilities that are not licensed as Intensive Residential Treatment Services (IRTS) * Room and board associated with Intensive Residential Treatment Services (IRTS) * Treatment and room and board services at certain childern’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:   * alcohol misuse screening and counseling including Screening Brief Intervention Referral to Treatment (SBIRT) authorized services and comprehensive assessments * treatment of drug abuse * group or individual counseling by a qualified clinician * subacute detoxification in a residential addiction program * alcohol and/or drug services in an intensive outpatient treatment center * extended-release Naltrexone (vivitrol) treatment * outpatient medication assisted treatment * substance use disorder treatment coordination * peer recovery support * detoxification (only when inpatient hospitalization is medically necessary because on conditions resulting from injury or medical complications during detoxification) * withdrawal management   A qualified professional who is part of the Plan 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 do not 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. | $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 is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor’s, 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 is more intense than the care received in your doctor’s, therapist’s, LMFT, or licensed professional counselor’s office but less intense than partial hospitalization.  [*Network plans that do not have an in-network community mental health center may add*: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | Physician/provider services, including doctor’s office visits  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 is not in the same location as the member). Plans may refer members to their 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 * Non-routine dental care. Covered services are limited to: * surgery of the jaw or related structures * setting fractures of the jaw or facial bones * pulling teeth before radiation treatments of neoplastic cancer * services that would be covered when provided by a physician   For information about other dental services we cover, refer to the “Dental services” section of this chart.   * Preventive and physical exams * Family Planning services. For more information, refer to the “Family planning” section of this chart * 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. | Prostate cancer screening exams  [*Plans that cover men under age 65 must include*:For men age 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 are not 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*.] |
| 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.  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 * 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 nursing facilities * lab tests given by nursing facilities * X-rays and other radiology services given by nursing facilities * appliances, such as wheelchairs, usually given by nursing facilities * physician/provider services   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 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 | $0 |
| Apple icon indicates preventive services. | Smoking and tobacco use cessation  If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:   * We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.   If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:   * We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.   [*List any additional benefits offered*.] | $0  [*List copays for supplemental benefits*.] |
|  | 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 will provide the most appropriate and cost-effective transportation. Our plan is not required to provide transportation to your Primary Care Clinic if it is over 30 miles from your home or if you choose a specialty provider that is more than 60 miles from your home. Call <phone number> if you do not have a Primary Care Clinic that is available within 30 miles of your home and/or you do not have a specialty provider that is available within 60 miles of your home.   * Non-emergency ambulance * Volunteer driver transport * Unassisted transport (taxi or public transportation) * Assisted transportation * Lift-equipped/ramp transport * Protected transportation * Stretcher transport   Note: Our plan does not cover mileage reimbursement (for example, when you use your own car), meals, lodging, and parking, also including out of state travel. These services are not covered under the plan but may be available through the local county or tribal agency. Call your local county or tribal agency for more information.  [*MCOs may include additional information on how to access transportation services. MCOs are not allowed to include information regarding a penalty for missed rides.*] |  |
|  | 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 is not possible, or it is unreasonable to obtain services from network providers (for example, when you are outside the plan’s service area and you require medically needed immediate services for an unseen condition but it is 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 |
|  | [*If the following benefit is not applicable, delete this row.*  Value-Based Insurance Design (VBID) Model  *Enrollees with chronic condition(s), enrollees who qualify for “Extra Help”, or enrolees in geographic areas that meet certain critieria may be eligible for VBID targeted supplemental benefits and/or reduced cost sharing. The eligibility criteria and benefits must be listed here if applicable. The benefits listed here must be approved in the bid. Describe the nature of the benefits and eligibility critieria here.*] | [*List copays*] |
| 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, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.  For people at high risk of glaucoma, 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 age 50 and over] * Hispanic Americans [*plans that cover under 65 must include*: who are 65 or over]   [*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 cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.  We also cover the following:   * Eye exams * Initial eyeglasses, when medically necessary. (eyeglass frame selection may be limited). * Replacement eyeglasses, when medically necessary; Identical replacement of covered eyeglasses for loss, theft, or damage beyond repair.   **This benefit is continued on the next page** | [*List copays*.]  [*List copays for additional benefits*.] |
|  | **Vision care (continued)**   * 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 does not 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 the preventive services you need (including screenings and shots), **and** * referrals for other care if you need it.   **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |

# 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 is 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 are not 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 annual 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 related to getting the out-of-area coverage. If you allow extended periods of enrollment out-of-area per the exception in 42 CFR §422.74(b)(4)(iii) (for more than 6 months up to 12 months), also explain that here based on the language suggested below*:

If you are out of the plan’s service area for more than 6 months at a time but do not 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 remain enrolled in our plan when you are 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 are 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 will 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 are available through Medicare or Medical Assistance.

## G1. 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. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

**For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis**

* The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

**For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis**

* The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

**For drugs that may be covered by 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*.

**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

**G2. Other Services**

The following services are not covered by us under the plan but may be available through another source, such as the state, county, federal government, or tribe. To find out more about these services, call 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) will replace PCA services at the member’s annual assessment starting October 1, 2024).*]
* [*SNBC Insert: Relocation Service Coordination (RSC)*]
* [*SNBC Inser: 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 are not licensed as Intensive Residential Treatment Services (IRTS)
* Room and board associated with Intensive Residential Treatment Services (IRTS)
* Services provided by a state regional treatment center or a state-owned long-term care facility unless approved by us or the service is ordered by a court under conditions specified in law
* Services provided by federal institutions
* [*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 is not otherwise responsible. (Refer to the “Nursing facility care” and the “Skilled nursing facility (SNF) care” sections in the Benefits Chart for additional information.)
* 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 do not pay for these benefits. Medicare and Medical Assistance do not 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 do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not 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 does not 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 may add parenthetical references to the Benefits Chart for descriptions of covered services and items as appropriate. Plans may 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 are not 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 is needed because of an accidental injury or to improve a part of the body that is not 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 may 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 will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.