Chapter 4: Covered Items and Services

Introduction

This chapter tells you about the services <plan name> covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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

[The plan 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 items and services

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

Because you are a FIDA-IDD Participant, you pay nothing for your covered items and services as long as you follow <plan name>’s rules. Refer to Chapter 3 [plan may insert reference, as applicable] for details about the plan’s rules.

If you need help understanding what services are covered, call your Care Manager and/or Participant Services at <Participant Services number>.

## A1. During public health emergencies

[*Plans providing required coverage and permissible flexibilities to Participants 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 Participants can get more details.*]

# Rules against providers charging you for covered items or services

We do not allow <plan name> providers to bill you for covered items or 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 items and services.** If you do, refer to Chapter 7 [plan may insert reference, as applicable] or call Participant Services.

# About our plan’s Covered Items and Services Chart

The Covered Items and Services Chart in Section D tells you which items and services <plan name> pays for. It lists items and services in alphabetical order and explains the covered items and services. [If the plan includes an index at the end of the chapter, it should insert: To find a service in the chart, you can also use the index at the end of the chapter.]

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

* Your Medicare and Medicaid covered items and services must be provided according to the rules set by Medicare and Medicaid.
* The items and services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need items and services to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger your life, result in illness or infirmity, interfere with your capacity for normal activity, threaten some significant handicap or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. [The plan should add the state-specific definition of “medically necessary” as appropriate and ensure that it is updated and used consistently throughout Participant material models.]
* You get your care from a network provider. A network provider is a provider who works with <plan name>. In most cases, <plan name> will not pay for care you get from an out-of-network provider, unless it is approved by your Interdisciplinary Team (IDT) or <plan name>. Chapter 3 [plan may insert reference, as applicable] has more information about using network and out-of-network providers.
* You have an IDT that will arrange and manage your care. For more information on your IDT, refer to Chapter 3 [plan may insert reference, as applicable].
* Most of the items and services listed in the Covered Items and Services Chart are covered only if your IDT, <plan name>, or an authorized provider approves them. This is called prior authorization (PA). The Covered Items and Services Chart tells you when an item or service does not require PA.
* [Insert if plan is offering targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI)”* in section B-19 of the Plan Benefit Package submission: **Important Benefit Information for Participants with Certain Chronic Conditions.** If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:
  + [List all applicable chronic conditions here.]
  + [If offering SSBCI, include information about the process and/or criteria for determining eligibility for SSBCI. Plan must also deliver a written summary of the SSBCI offered to each chronically ill Participant eligible for SSBCI.]

Please refer to the “Help with certain chronic conditions” row in the Covered Items and Services Chart for more information.]

* [Insert as applicable: Most **or** All] preventive services are covered by <plan name>. You will find this apple Apple icon represents preventive services next to preventive services in the Covered Items and Services Chart.

[Instructions on completing the Covered Items and Services Chart:

* The plan must identify preventive services with the apple icon.
* The plan may insert any additional benefits information based on the plan’s approved benefit package that is not captured in the Covered Items and Services Chart or in the exclusions section. Additional benefits should be placed alphabetically in the chart.
* The plan 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.
* For services that do not require PA, the plan may add at the end of the service description: **This service does not require PA.**
* A plan offering targeted supplemental benefits in section B-19 of the Plan Benefit Package submission must:
  + Deliver to each clinically-targeted enrollee a written summary of those benefits so that such enrollees are notified of the “Uniformity Flexibility” benefits for which they are eligible.
  + Update the Covered Items and Services Chart to include details, as applicable, about the exact targeted reduced cost sharing amount for each specific service and/or the additional supplemental benefits being offered.]

# The Covered Items and Services Chart

[When a benefit continues from one page to the next, the plan enters 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, the plan should enter the benefit name again in bold followed by **(continued)**. The plan may refer to **Durable medical equipment (DME) and related supplies** and other examples later in this chart as examples. The plan should also be aware that the flow of benefits from one page to the next may vary after plan-customized information is added, which may necessitate adding and/or removing these instructions in other services as needed.]

| Services that <plan name> pays for | | What you must pay |
| --- | --- | --- |
| Apple icon represents preventive services | Abdominal aortic aneurysm screening  The plan will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. | $0 |
|  | Acupuncture for chronic low back pain  The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as:   * lasting 12 weeks or longer; * not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); * not associated with surgery; **and** * not associated with pregnancy.   The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year.  Acupuncture treatments must be stopped if you don’t get better or if you get worse. | $0 |
|  | Adult day health care  <Plan name> will pay for adult day health care for Participants who are functionally impaired, not homebound, and who require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services.  Adult day health care includes the following services:  medical  nursing  food and nutrition  social services  rehabilitation therapy  leisure time activities, which are a planned program of diverse meaningful activities  dental  pharmaceutical  other ancillary services | $0 |
|  | AIDS adult day health care  <Plan name> will pay for AIDS adult day health care programs for Participants with HIV.  AIDS Adult Day Health Care programs include the following services:  individual and group counseling/education provided in a structured program setting  nursing care (including triage/assessment of new symptoms)  medication adherence support  nutritional services (including breakfast and/or lunch)  rehabilitative services  substance abuse services  mental health services  HIV risk reduction services | $0 |
| Apple icon indicates preventive services. | Alcohol misuse screening and counseling  The plan will 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.  This service does not require PA. | $0 |
|  | Ambulance services  Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.  Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by your IDT or <plan name>.  In cases that are not emergencies, your IDT or <plan name> may authorize use of 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 |
|  | Ambulatory surgical center services  <Plan name> will pay for covered surgical procedures provided at ambulatory surgical centers. | $0 |
| Apple icon represents preventive services | Annual wellness visit / routine physical exam  If you have been in Medicare Part B for more than 12 months, you can get an annual wellness checkup. This is to develop or update a prevention plan based on your current health and risk factors. <Plan name> will pay for this once every 12 months.  **Note:** You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.  This service does not require PA. | $0 |
|  | Assertive community treatment (ACT)  <Plan name> will pay for ACT services. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting. | $0 |
| Apple icon represents preventive services | Bone mass measurement  <Plan name> will pay for certain procedures for Participants 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.  <Plan name> will pay for the services once every 24 months, or more often if they are medically necessary. <Plan name> will also pay for a doctor to look at and comment on the results.  This service does not require PA. | $0 |
| Apple icon represents preventive services | Breast cancer screening (mammograms)  <Plan name> will pay for the following services:  one baseline mammogram between the ages of 35 and 39  one screening mammogram every 12 months for women age 40 and older  clinical breast exams once every 24 months  This service does not require PA. | $0 |
|  | Cardiac (heart) rehabilitation services  <Plan name> will pay for cardiac rehabilitation services such as exercise, education, and counseling. Participants must meet certain conditions with a provider’s order. <Plan name> also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.  This service does not require PA. | $0 |
| Apple icon represents preventive services | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  <Plan name> pays for one visit a year with your PCP to help lower your risk for heart disease. During this visit, your doctor may:  discuss aspirin use,  check your blood pressure, **or**  give you tips to make sure you are eating well.  This service does not require PA. | $0 |
| Apple icon represents preventive services | Cardiovascular (heart) disease screening and testing  <Plan name> pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.  This service does not require PA. | $0 |
|  | Care management  Care management is individually designed to help the Participant get access to needed services. Care management helps to assure the Participant’s health and welfare and increase the Participant’s independence and quality of life. Refer to Chapter 3 [plan may insert reference, as applicable] for more information about care management. | $0 |
| Apple icon represents preventive services | Cervical and vaginal cancer screening  <Plan name> will pay for the following services:  for all women: Pap tests and pelvic exams once every 24 months  for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months  for women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months  This service does not require PA. | $0 |
|  | Chemotherapy  <Plan name> will pay for chemotherapy for cancer patients. Chemotherapy is covered when it is provided in an inpatient or outpatient unit of a hospital, a provider’s office, or a freestanding clinic. | $0 |
|  | Chiropractic services  <Plan name> will pay for the following services:  adjustments of the spine to correct alignment | $0 |
| Apple icon represents preventive services | Colorectal cancer screening  <Plan name> will pay for the following:  Barium enema   * Covered once every 48 months if you're 45 or over and do not meet high risk criteria, when the test is used instead of a flexible sigmoidoscopy * Covered once every 24 months if you're at high risk for colorectal cancer, when this test is used instead of a colonoscopy.   Colonoscopy   * Covered once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy.   Multitarget stool DNA   * Covered once every 3 years if you’re 45 to 85 years of age and do not meet high risk criteria.   Blood-based Biomarker Tests   * + Covered once every 3 years if you’re 45 to 85 years of age and do not meet high risk criteria   Fecal occult blood test   * Covered once every 12 months if you're 45 or older.   Guaiac-based fecal occult blood test or fecal immunochemical test   * Covered once every 12 months if you're 50 or older.   **This benefit is continued on the next page** | $0 |
|  | Colorectal cancer screening (continued)  Flexible sigmoidoscopy   * Covered once every 48 months for most people 45 or older if you are at high risk for colorectal cancer from the last flexible sigmoidoscopy or barium enema. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy.   As of January 1, 2023, colorectal cancer screening tests include a follow-on screening colonoscopy after a covered non-invasive stool-based colorectal cancer screening test returns a positive result.  This service does not require PA. |  |
|  | Consumer directed personal assistance services (CDPAS)  <Plan name> will pay for CDPAS, which provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse.  Participants who choose CDPAS have flexibility and freedom to choose their caregivers. The Participant or the person acting on the Participant's behalf is responsible for recruiting, hiring, training, supervising, and, if necessary, terminating caregivers providing CDPAS services. | $0 |
|  | Continuing day treatment  <Plan name> will pay for continuing day treatment. This service helps Participants maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem.  Services include:  assessment and treatment planning  discharge planning  medication therapy  medication education  case management  health screening and referral  rehabilitative readiness development  psychiatric rehabilitative readiness determination and referral  symptom management | $0 |
|  | Day treatment - Office for People With Developmental Disabilities (OPWDD)  <Plan name> will pay for OPWDD day treatment. Day treatment is a combination of diagnostic and treatment services provided to individuals with intellectual and developmental disabilities in need of a broad range of clinically supported and structured habilitation services. | $0 |
|  | Defibrillator (implantable automatic)  <Plan name> will pay for defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting. | $0 |
|  | [Plans should modify this row to accurately describe the supplemental benefit offered.]  Dental services  <Plan name> will pay for the following dental services:  oral exams once every six months  cleaning once every six months  dental x-rays once every six months  diagnostic services  restorative services  endodontics, periodontics, and extractions  dental prosthetics and orthotic appliances required to alleviate a serious condition, including one that affects a Participant’s employability  other oral surgery  dental emergencies  other necessary dental care  X-rays and other dental services must be authorized by your dentist. However, dental services provided through Article 28 Clinics operated by Academic Dental Centers do not require PA.  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. | $0 |
| Apple icon represents preventive services | Depression screening  <Plan name> will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and recommendations for additional treatments.  This service does not require PA. | $0 |
| Apple icon represents preventive services | Diabetes screening  <Plan name> will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:  high blood pressure (hypertension)  history of abnormal cholesterol and triglyceride levels (dyslipidemia)  obesity  history of high blood sugar (glucose)  Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.  Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.  This service does not require PA. | $0 |
| Apple icon represents preventive services | Diabetic self-management training, services, and supplies  <Plan name> will pay for the following services for all people who have diabetes (whether they use insulin or not):  Supplies to monitor your blood glucose, including the following:   * a blood glucose monitor * blood glucose test strips * lancet devices and lancets * glucose-control solutions for checking the accuracy of test strips and monitors   For people with diabetes who have severe diabetic foot disease, <plan name> will pay for the following:   * one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** * one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)   <Plan name> will also pay for fitting the therapeutic custom-molded shoes or depth shoes.  <Plan name> will pay for training to help you manage your diabetes, in some cases. | $0 |
|  | Diagnostic testing  Refer to “Outpatient diagnostic tests and therapeutic services and supplies” in this chart. | $0 |
|  | Directly Observed Therapy for Tuberculosis (TB/DOT)  TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen. | $0 |
|  | Durable medical equipment (DME) and related supplies  DME includes items such as:  wheelchairs  crutches  powered mattress systems  diabetic supplies  hospital beds ordered by a provider for use in the home  intravenous (IV) infusion pumps  speech generating devices  oxygen equipment and supplies  nebulizers  walkers  Other items may be covered.  [A plan that does not limit the DME brands and manufacturers that it will cover, insert:We will 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.]  [A plan that limits the DME brands and manufacturers that it will cover, insert the following (for more information about this requirement, refer to the Medicare Managed Care Manual, Chapter 4, Section 10.12.1 et seq.): With this Participant Handbook, we sent you <plan name>’s list of DME. The list tells you the brands and makers of DME that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at <URL>.  **This benefit is continued on the next page** | $0 |
|  | Durable medical equipment (DME) and related supplies (continued)  Generally, <plan name> covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your IDT or <plan name> authorizes a doctor or other provider’s request for the brand. However, if you are new to <plan name> and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your Care Manager or IDT to decide what brand is medically right for you after this 90-day period. (If you disagree with your Care Manager or IDT, you can ask to be referred for a second opinion.)  If you (or your provider) do not agree with the IDT or <plan name> coverage decision, you or your provider may file an appeal. You can also file an appeal if you do not agree with your provider’s decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9 [the plan may insert reference, as applicable].)] |  |
|  | Emergency care  Emergency care means services that are:  given by a provider trained to give emergency services, **and**  needed to treat a medical or behavioral health emergency.  A medical or behavioral health emergency is a condition with severe symptoms, severe pain, or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:  serious risk to your health or to that of your unborn child; **or**  serious impairment to bodily functions; **or**  serious dysfunction of any bodily organ or part; **or**  serious disfigurement of such person; **or**  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 that of your unborn child.   This coverage is within the U.S. and its territories.  This service does not require PA. | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [The plan 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 <plan name> approves your stay.)]. |
|  | [The plan should modify this as necessary.]  Family planning services  The law lets you choose any provider – whether a network provider or out-of-network provider – to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office.  <Plan name> will pay for the following services:  family planning exam and medical treatment  family planning lab and diagnostic tests  family planning methods (birth control pills, patch, ring, IUD, injections, implants)  family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap, emergency contraception, pregnancy tests)  counseling and diagnosis of infertility, and related services  counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions, as part of a family planning visit  treatment for sexually transmitted infections (STIs)  voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)  abortion  These services do not require PA. | $0 |
| Apple icon represents preventive services | Health and wellness education programs  <Plan name> will pay for health and wellness education for Participants and their caregivers, which includes:  classes, support groups, and workshops  educational materials and resources  website, email, or mobile application communications  These services are provided on topics including, but not limited to: heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis.  This benefit also includes annual preventive care reminders and caregiver resources.  This service does not require PA. | $0 |
|  | Hearing services  <Plan name> pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.  Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing.  Services include:  hearing aid selecting, fitting, and dispensing  hearing aid checks following dispensing  conformity evaluations and hearing aid repairs  audiology services, including examinations and testing  hearing aid evaluations and hearing aid prescriptions  hearing aid products, including hearing aids, earmolds, special fittings, and replacement parts when authorized by an audiologist | $0 |
|  | [If this benefit is not applicable, the plan should delete this row.]  Help with certain chronic conditions  [A plan offering targeted “Uniformity Flexibility” supplemental benefits and/or “*Special Supplemental Benefits for the Chronically Ill (SSBCI),”* which Participants with certain chronic condition(s) may be eligible to receive from a network provider, should include information about the specific benefits. If offering SSBCI, the plan must also list the chronic conditions and benefits and describe the nature of the benefits and the eligibility criteria. The benefits listed here must be approved in the Plan Benefit Package submission.] | [List copays.] |
| Apple icon represents preventive services | HIV screening  <Plan name> pays for one HIV screening exam every 12 months for people who:  ask for an HIV screening test, **or**  are at increased risk for HIV infection.  For women who are pregnant, <plan name> pays for up to three HIV screening tests during a pregnancy.  This service does not require PA. | $0 |
|  | Home-delivered and congregate meals/Meal benefit  This service allows up to two meals per day for Participants who cannot prepare or access nutritionally adequate meals for themselves. | $0 |
|  | Home health services  Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency.  <Plan name> will pay for the following services, and maybe other services not listed here:  part-time or intermittent skilled nursing and home health aide services  physical therapy, occupational therapy, and speech therapy  medical and social services  medical equipment and supplies | $0 |
|  | Home infusion therapy  The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:   * The drug or biological substance, such as an antiviral or immune globulin; * Equipment, such as a pump; **and** * Supplies, such as tubing or a catheter.   The plan will cover home infusion services that include but are not limited to:   * Professional services, including nursing services, provided in accordance with your Life Plan; * Participant 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.*] | $0 |
|  | Home visits by medical personnel  <Plan name> will cover home visits by medical personnel to provide diagnosis, treatment, and wellness monitoring. The purpose of these home visits is to preserve the Participant’s functional capacity to remain in the community. Wellness monitoring includes disease prevention, health education, and identifying health risks that can be reduced. | $0 |
|  | 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 a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will pay for the following while you are getting hospice services:  drugs to treat symptoms and pain  short-term respite care  home care  **Hospice services and services covered by Medicare Part A or B are billed to Medicare.**  Refer to Section F of this chapter for more information.  **For services covered by <plan name> but not covered by Medicare Part A or B:**  <Plan name> will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay [insert as appropriate: the plan’s cost sharing amount **or** nothing] for these services.  **This benefit is continued on the next page** | $0 |
|  | Hospice care (continued)  **For drugs that may be covered by <plan name>’s Medicare Part D benefit:**  Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plan may insert reference, as applicable].  **Note:** If you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [The plan should include a phone number or other contact information.]  [Insert if applicable, edit as appropriate: Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.] |  |
| Apple icon represents preventive services | Immunizations  <Plan name> will pay for the following services:  pneumonia vaccine  flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary  hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B   * COVID-19 vaccine   other vaccines if you are at risk and they meet Medicare Part B coverage rules  <Plan name> will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plan may insert reference, as applicable] to learn more.  These services do not require PA. | $0 |
|  | Inpatient acute hospital care, including substance abuse and rehabilitative services  [List any restrictions that apply.]  <Plan name> will pay for the following services, and maybe other services not listed here:  semi-private room (or a private room if it is medically necessary)  meals, including special diets  regular nursing services  costs of special care units, such as intensive care or coronary care units  drugs and medications  lab tests  X-rays and other radiology services  needed surgical and medical supplies  appliances, such as wheelchairs  operating and recovery room services  physical, occupational, and speech therapy  inpatient substance abuse services  blood, including storage and administration  physician services  In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.  **This benefit is continued on the next page** | $0  You must get approval from <plan name> to keep getting inpatient care at an out-of-network hospital after your emergency is under control. |
|  | Inpatient acute hospital care, including substance abuse and rehabilitative services (continued)  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [The plan 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 <plan name> provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [The plan may further define the specifics of transplant travel coverage.] |  |
|  | Inpatient services in a psychiatric hospital  <Plan name> will pay for mental health care services that require a hospital stay, including days in excess of the Medicare 190-day lifetime maximum. | $0 |
|  | [If the plan has no day limitations on a plan’s hospital or nursing facility coverage, it 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  If your inpatient stay is not reasonable and necessary, <plan name> will not pay for it.  However, in some cases <plan name> will pay for services you get while you are in the hospital or a SNF. <Plan name> will pay for the following services, and maybe other services not listed here:  provider 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** * replace all or part of 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 the Participant’s condition.  physical therapy, speech therapy, and occupational therapy | $0 |
|  | Intensive psychiatric rehabilitation treatment (IPRT) programs  <Plan name> will pay for time limited, active psychiatric rehabilitation designed to:  help a Participant form and achieve mutually agreed upon goals in living, learning, working, and social environments  intervene with psychiatric rehabilitative technologies to help a Participant overcome functional disabilities | $0 |
|  | Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)  <Plan name> will pay for a facility that provides comprehensive and individualized health care and rehabilitation services to a Participant to promote their functional status and independence. | $0 |
|  | Kidney disease services and supplies, including End-Stage Renal Disease (ESRD) services  <Plan name> will pay for the following services:  kidney disease education services to teach kidney care and help Participants make good decisions about their care.   * You must have stage IV chronic kidney disease, and your IDT or <plan name> must authorize it. * <Plan name> will cover up to six sessions of kidney disease education services per lifetime.   outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 [plan may insert reference, as applicable]*,* or when your provider for this service is temporarily unavailable or inaccessible  inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care  **This benefit is continued on the next page** | $0 |
|  | Kidney disease services and supplies, including End-Stage Renal Disease (ESRD) services (continued)  self-dialysis training, including training for you and anyone helping you with your home dialysis treatments  home dialysis equipment and supplies  certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply  Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.  Kidney disease education services do not require PA. |  |
| Apple icon indicates preventive services. | Lung cancer screening  The plan will pay for lung cancer screening every 12 months if you:  are aged 50-77, **and**  have a counseling and shared decision-making visit with your doctor or other qualified provider, **and**  have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.  After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [List any additional benefits offered.] | $0 |
| Apple icon indicates preventive services. | Medical nutrition therapy  This benefit is for Participants with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when [insert as appropriate: referred **or** ordered] by your provider.  <Plan name> will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes <plan name>, a Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a provider’s request and approval by your IDT or <plan name>. A provider must prescribe these services and renew the request to the IDT or to <plan name> each year if your treatment is needed in the next calendar year.  This service does not require PA. | $0 |
|  | Medical social services  <Plan name> will pay for medical social services, which includes the assessment of social and environmental factors related to the Participant’s illness and need for care.  Services include:  home visits to the individual, family, or both  visits to prepare to transfer the Participant to the community  patient and family counseling, including personal, financial, and other forms of counseling services | $0 |
| Apple icon indicates preventive services. | Medicare Diabetes Prevention Program (MDPP)  The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:  long-term dietary change, **and**  increased physical activity, **and**  ways to maintain weight loss and a healthy lifestyle | $0 |
|  | Medicare Part B prescription drugs  [*A plan that will or expects to use Part B step therapy should indicate the Part B drug categories below that will or may be subject to Part B step therapy as well as a link to a list of drugs that will be subject to Part B step therapy. The link may be updated throughout the year and any changes added at least 30 days prior to implementation per 42 CFR 422.111(d).*]  These drugs are covered under Part B of Medicare. <Plan name> will pay for the following drugs:  drugs you don’t usually give yourself and are injected or infused while you are getting provider, 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 DME (such as nebulizers) that were authorized by your IDT or <plan name>  clotting factors you give yourself by injection if you have hemophilia  immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant  osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a provider certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself  antigens  certain oral anti-cancer drugs and anti-nausea drugs  certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents [the plan may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)  IV immune globulin for the home treatment of primary immune deficiency diseases  [Insert if applicable: The following link will take you to a list of Part B drugs that may be subject to step therapy: <hyperlink>.]  **This benefit is continued on the next page** | $0 |
|  | Medicare Part B prescription drugs (continued)  We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.  Chapter 5 [plan may insert reference, as applicable] explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.  Chapter 6 [plan may insert reference, as applicable] provides additional information about your outpatient prescription drug coverage. |  |
|  | Medication therapy management (MTM) services  <Plan name> provides medication therapy management (MTM) services for Participants who take medications for different medical conditions. MTM programs help Participants and their providers make sure that Participants’ medications are working to improve their health.  Chapter 5 [plan may insert reference, as applicable] provides additional information about MTM programs. | $0 |
|  | Mobile mental health treatment  <Plan name> will pay for mobile mental health treatment, which includes individual therapy that is provided in the home. This service is available to Participants who have a medical condition or disability that limits their ability to come into an office for regular outpatient therapy sessions. | $0 |
|  | Moving assistance  <Plan name> will pay for a Participant who is transitioning from an institutional setting to a community-based setting. This service covers the cost of physically moving the Participant’s furnishings and other belongings to the community-based setting where s/he will reside. Plan must use a moving company licensed/certified by the New York State Department of Transportation. | $0 |
|  | Nurse advice call line  <Plan name> has a nurse advice line, which is a toll-free phone service that Participants can call 24 hours a day, 7 days a week. Participants can call the nurse advice line for answers to general health related questions and for assistance in accessing services through <plan name>. | $0 |
|  | Nursing facility care  <Plan name> will pay for nursing facilities for Participants who need 24-hour nursing care and supervision outside of a hospital. | $0 |
| Apple icon represents preventive services | Nutrition (includes nutritional counseling and educational services)  <Plan name> will pay for nutrition services provided by a qualified nutritionist. Services include:  assessment of nutritional needs and food patterns  planning for providing food and drink appropriate for the individual’s physical and medical needs and environmental conditions  These services do not require PA. | $0 |
| Apple icon represents preventive services | Obesity screening and therapy to keep weight down  If you have a body mass index of 30 or more, <plan name> will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your Care Manager or PCP to find out more.  This service does not require PA. | $0 |
|  | Opioid treatment program (OTP) services  The plan will pay for the following services to treat opioid use disorder (OUD):  intake activities  periodic assessments  medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications  substance use counseling  individual and group therapy  testing for drugs or chemicals in your body (toxicology testing)  [List any additional benefits offered, with the exception of meals and transportation.] | $0 |
|  | OPWDD certified outpatient clinic  <Plan name> will pay for clinical services provided at an Article 16 clinic. Clinical services include:  Rehabilitation/habilitation services (e.g., physical therapy, occupational therapy, psychology, speech and language pathology, social work);  Medical/dental services; **and**  Health care services (e.g., nursing, dietetics and nutrition, audiology, podiatry). | $0 |
|  | Other supportive services the IDT determines are necessary  <Plan name> will pay for additional supportive services or items determined by the Participant’s IDT to be necessary for the Participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the Participant. One example is <plan name> paying for a blender to puree foods for a Participant who cannot chew. | $0 |
|  | Outpatient blood services  Blood, including storage and administration, beginning with the first pint you need. | $0 |
|  | Outpatient diagnostic tests and therapeutic services and supplies  <Plan name> will pay for the following services, and maybe other services not listed here:  CT scans, MRIs, EKGs and X-rays when a provider orders them as part of treatment for a medical problem  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  medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition  blood, including storage and administration  other outpatient diagnostic tests | $0 |
|  | Outpatient hospital services  <Plan name> pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  <Plan name> will pay for the following services, and maybe other services not listed here:  services in an emergency department or outpatient clinic, such as outpatient surgery or observation services   * Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” * Sometimes you can be in the hospital overnight and still be an “outpatient.” * You can get more information about being an inpatient or an outpatient in this fact sheet: [www.medicare.gov/media/11101](https://www.medicare.gov/media/11101).   labs and diagnostic tests billed by the hospital  mental health care, including care in a partial-hospitalization program, if a provider 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 Covered Items and Services Chart  some drugs that you can’t give yourself  **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff. | $0 |
|  | Outpatient mental health care  <Plan name> will 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), **or** * any other Medicare-qualified mental health care professional as allowed under applicable state laws.   <Plan name> will pay for the following services:   * individual therapy sessions * group therapy sessions * clinic services [The plan should include any Medicaid limitations that apply (e.g., number of visits).] * day treatment [The plan should include any Medicaid limitations that apply (e.g., number of visits).] * psychosocial rehab services [The plan should include any Medicaid limitations that apply (e.g., number of visits).]   Participants may directly access one assessment from a network provider in a twelve (12)-month period without getting PA. | $0 |
|  | Outpatient rehabilitation services  <Plan name> will pay for Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Therapy (SLT).  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
|  | Outpatient surgery  <Plan name> will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. | $0 |
|  | Palliative care  <Plan name> will pay for interdisciplinary end-of-life care and consultation with the Participant and his/her family members. These services help to prevent or relieve pain and suffering and to enhance the Participant's quality of life.  Services include:  family palliative care education  pain and symptom management  bereavement services  massage therapy  expressive therapies  These services do not require PA. | $0 |
|  | Partial hospitalization  Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center. Partial hospitalization is more intense than the care in a provider or therapist’s office and is an alternative to inpatient hospitalization.  <Plan name> will pay for partial hospitalization to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Services include:  assessment and treatment planning  health screening and referral  symptom management  medication therapy  medication education  verbal therapy  case management  psychiatric rehabilitative readiness determination  referral and crisis intervention  [If the plan does not have an in-network community mental health center, it 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 |
|  | Personal care services  <Plan name> will pay for personal care services to assist Participants with activities such as personal hygiene, dressing, feeding, and nutritional and environmental support function tasks (meal preparation and housekeeping). PCS must be medically necessary, ordered by the Participant’s physician, and provided by a qualified person according to a plan of care. | $0 |
|  | Personal emergency response services (PERS)  <Plan name> will pay for PERS, which is an electronic device that enables certain high-risk Participants to reach out for help during an emergency. | $0 |
|  | Personalized recovery oriented services (PROS)  <Plan name> will pay for PROS to assist individuals in recovery from the disabling effects of mental illness. This includes the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations. | $0 |
|  | Pharmacy benefits (outpatient)  <Plan name> will pay for certain generic, brand, and non-prescription drugs to treat a Participant’s illness or condition. Chapters 5 and 6 [plan may insert references, as applicable] provide additional information about your pharmacy benefits. | $0 |
|  | Physician/Provider services, including Primary Care Provider (PCP) office visits  <Plan name> will pay for the following services:   * medically necessary health care or surgery services given in places such as:   + physician’s office   + certified ambulatory surgical center   + hospital outpatient department * consultation, diagnosis, and treatment by a specialist * basic hearing and balance exams given by your PCP or a 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 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 Participant). Plans may refer Participants to their medical coverage policy here].] * You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. [*Plans may modify as necessary if benefits include out-of-network coverage of additional telehealth services as mandatory supplemental benefits.*] * [List the available means of electronic exchange used for each Part B service offered as an additional telehealth benefit along with any other access instructions that may apply.]   **This benefit is continued on the next page** | $0 |
|  | Physician/Provider services, including Primary Care Provider (PCP) office visits (continued)   * [*Insert if the plan’s service area and providers/locations qualify for telehealth services under original Medicare requirements in section 1834(m) of the Act:* Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for Participants in certain rural areas or other places approved by Medicare] * telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the Participant’s home * telehealth services to diagnose, evaluate, or treat symptoms of a stroke * telehealth services for Participants with a substance use disorder or co-occurring mental health disorder * 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   **This benefit is continued on the next page** |  |
|  | Physician/Provider services, including Primary Care Provider (PCP) office visits (continued)   * evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:   + you’re not a new patient **and**   + the evaluation isn’t related to an office visit in the past 7 days **and**   + the evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment * consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient * second opinion [insert if appropriate: by another network provider] before surgery   Participants may use PCPs without first getting PA. |  |
|  | Podiatry services  <Plan name> will pay for the following services:  care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)  routine foot care for Participants with conditions affecting the legs, such as diabetes | $0 |
| Apple icon represents preventive services | Preventive services  <Plan name> will pay for all preventive tests and screenings covered by Medicare and Medicaid to help prevent, find, or manage a medical problem. This includes, but is not limited to, all the preventive services listed in this chart. You will find this apple **Apple icon represents preventive services** next to preventive services in this chart. | $0 |
|  | Private duty nursing services  <Plan name> will pay for private duty nursing services covered for continuous or intermittent skilled nursing services. These services are provided in the Participant’s home and are beyond what a certified home health agency can provide. | $0 |
| Apple icon represents preventive services | Prostate cancer screening exams  For men age 50 and older, <plan name> will pay for the following services once every 12 months:  a digital rectal exam  a prostate specific antigen (PSA) test  This service does not require PA. | $0 |
|  | Prosthetic devices and related supplies  Prosthetic devices replace all or part of a body part or function. <Plan name> will pay for the following prosthetic devices, and maybe other devices not listed here:  colostomy bags and supplies related to colostomy care  pacemakers  braces  prosthetic shoes  artificial arms and legs  breast prostheses (including a surgical brassiere after a mastectomy)  orthotic appliances and devices  support stockings  orthopedic footwear  <Plan name> will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. | $0 |
|  | Pulmonary rehabilitation services  <Plan name> will pay for pulmonary rehabilitation programs for Participants who have moderate to very severe chronic obstructive pulmonary disease (COPD). The Participant must have an order approved by the IDT or <plan name> for pulmonary rehabilitation from the provider treating the COPD. | $0 |
|  | Respiratory care services  <Plan name> will pay for respiratory therapy, which is an individually designed service provided in the home. Respiratory therapy includes preventive, maintenance, and rehabilitative airway-related techniques and procedures. | $0 |
| Apple icon represents preventive services | Sexually transmitted infections (STIs) screening and counseling  <Plan name> will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A PCP or other primary care practitioner must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.  <Plan name> will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. <Plan name> will pay for these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor’s office.  This service does not require PA. | $0 |
|  | Skilled nursing facility (SNF) care  <Plan name> covers an unlimited number of days of SNF care and there is no prior hospital stay required.  <Plan name> will pay for the following services, and maybe other services not listed here:  a semi-private room, or a private room if it is medically necessary  meals, including special diets  nursing services  physical therapy, occupational therapy, and speech therapy  drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors  blood, including storage and administration  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 will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept <plan name> 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 represents preventive services | Smoking and tobacco cessation (counseling to stop smoking or tobacco use)  If you use tobacco but do not have signs or symptoms of tobacco-related disease, you use tobacco and have been diagnosed with a tobacco-related disease, or you are taking medicine that may be affected by tobacco:  <Plan name> will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.  <Plan name> will pay for smoking cessation counseling for pregnant women and women up to six months after birth. This smoking cessation counseling is in addition to benefits for prescriptions and over-the-counter smoking cessation products.  This service does not require PA. | $0 |
|  | Substance abuse services: Opioid treatment services  <Plan name> will pay for opioid treatment services to help Participants manage addiction to opiates such as heroin. Opioid treatment programs administer medication, generally methadone by prescription, along with a variety of other clinical services.  These programs help Participants control the physical problems associated with opiate dependence and provide the opportunity for Participants to make major lifestyle changes over time. | $0 |
|  | Substance abuse services: Outpatient medically supervised withdrawal  <Plan name> will pay for medical supervision of Participants that are:  undergoing mild to moderate withdrawal  at risk of mild to moderate withdrawal  experiencing non-acute physical or psychiatric complications associated with their chemical dependence  Services must be provided under the supervision and direction of a licensed physician. | $0 |
|  | Substance abuse services: Outpatient substance abuse services  <Plan name> will pay for outpatient substance abuse services including individual and group visits.  Participants may directly access one assessment from a network provider in a twelve (12)-month period without getting PA. | $0 |
|  | Substance abuse services: Substance abuse program  <Plan name> will pay for substance abuse program services to provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the Participant, which, if not effectively dealt with, will interfere with the individual’s ability to remain in the community. | $0 |
|  | Supervised exercise therapy (SET)  The plan will pay for SET for Participants with symptomatic peripheral artery disease (PAD) [*insert if applicable:* who have a referral for PAD from the physician responsible for PAD treatment]. The plan will pay for:   * up to 36 sessions during a 12-week period if all SET requirements are met * an additional 36 sessions over time if deemed medically necessary by a health care provider   The SET program must be:   * 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in Participants 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 |  |
|  | Telehealth services  <Plan name> will pay for telehealth services for Participants with conditions that require frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services to reduce the need for in-office visits.  Participants eligible for this service include those with the following conditions: congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding.  These services do not require PA. | $0 |
|  | Transitional services  These services assist a Participant who is transitioning from an institutional setting to a home in the community where s/he will reside. These services cover expenses related to setting up a household such as:  payment of the first and last month’s rent;  utility and rental deposits;  purchase of basic essential household items such as furniture, linens, and kitchen supplies; **and**  health and safety assurances such as pest removal, allergen control, or one-time cleaning prior to occupancy.  These services are limited to a Participant transitioning from a nursing facility, Institution for Mental Disease (IMD) or ICF/IID to her/his home or the home of a family member where s/he will live. | $0 |
|  | Transportation services (emergency and non-emergency)  <Plan name> will pay for emergency and non-emergency transportation. Transportation is provided for medical appointments and services. Transportation is also available for non-medical events or services, such as religious services, community activities, or supermarkets, through transportation modes including but not limited to:  taxi  bus  subway  van  medical transport  ambulance  fixed wing or airplane transport  invalid coach  delivery  other means | $0 |
|  | Urgently needed care  Urgently needed care is care given to treat:  a non-emergency, **or**  a sudden medical illness, **or**  an injury, **or**  a condition that needs care right away.  If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your 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).  Urgent care does not include primary care services or services provided to treat an emergency medical condition.  This coverage is within the U.S. and its territories.  These services do not require PA. | $0 |
| Apple icon indicates preventive services. | Vision care: Eye and vision exams and eye care  The plan will pay for outpatient doctor services for the diagnosis and treatment of visual defects, eye disease, and eye injury. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Examinations for refraction are limited to every two (2) years unless medically necessary.  For people at high risk of glaucoma, <plan name> will pay for one glaucoma screening each year. People at high risk of glaucoma include:  people with a family history of glaucoma,  people with diabetes,  African-Americans who are age 50 and older, **and**  Hispanic Americans who are 65 or older.  Article 28 Clinic services may be directly accessed without PA from <plan name> or your IDT. | $0 |
|  | Vision Care: Eyeglasses (lenses and frames) and contact lenses  <Plan name> will pay for eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services, when authorized by an optometrist or ophthalmologist. Coverage also includes the repair or replacement of parts.  Eyeglasses and contact lenses are provided once every two years unless it is medically necessary to have them more frequently or unless the glasses or contact lenses are lost, damaged or destroyed.  [The plan should modify this description if it offers more than is covered by Medicare.] <Plan name> will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) <Plan name> will also pay for corrective lenses, frames, and replacements if you need them after a cataract removal without a lens implant.  Article 28 Clinic services may be directly accessed without PA from <plan name> or your IDT. | $0 |
| Apple icon represents preventive services | “Welcome to Medicare” Preventive Visit  <Plan name> covers the one-time “Welcome to Medicare” preventive visit. The visit includes:  a review of your health,  education and counseling about the preventive services you need (including screenings and shots), **and**  referrals for other care if you need it.  **Note:** We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. | $0 |
|  | Wellness counseling  <Plan name> will pay for wellness counseling to help medically stable Participants maintain their optimal health status.  A Registered Professional Nurse (RN) works with the Participant to reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. The RN is also able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma, or high cholesterol. The RN can help the Participant to identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder.  These services do not require PA. | $0 |

# Home and Community-Based Waiver Services Chart

[The plan should refer to and follow the instructions for Section D, The Covered Items and Services Chart, when a benefit continues from one page to the next in this section.]

| **Home and Community-Based Waiver Services that <plan name> pays for**  **Some services may have limitations. Contact your Care Manager for more information.** | | **What you must pay** |
| --- | --- | --- |
|  | Assistive Technology-Adaptive Devices  Includes items, equipment, or product system that is modified or customized to be used to increase, maintain, or improve functional capabilities. | $0 |
|  | Community Habilitation  This service is directed toward service delivery in community (non-certified) settings to promote independence and community integration. | $0 |
|  | Community Transition Services (CTS)  These services help a Participant transition from living in an institution to living in the community.  CTS includes:  the cost of moving furniture and other belongings  buying certain essential items such as linen and dishes  security deposits, including broker’s fees required to obtain a lease on an apartment or home  buying essential furnishings  set-up fees or deposits for utility or service access (for example, telephone, electricity, or heating)  health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy  CTS cannot be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems. | $0 |
|  | Day Habilitation  This service helps the Participant to achieve maximum functional level. The service is coordinated with any physical, occupational or speech therapies. The service may serve to reinforce skills, behaviors, or lessons taught in other settings. | $0 |
|  | Environmental Modifications  <Plan name> will pay for modifications to the home that are necessary to ensure the health, welfare, and safety of the Participant.  Environmental modifications may include:  installation of ramps and grab bars  widening of doorways  modifications of bathroom facilities  installation of specialized electrical or plumbing systems to accommodate necessary medical equipment  any other modification necessary to ensure the Participant’s health, welfare or safety | $0 |
|  | Fiscal Intermediary (FI)  This service is for Participants who are self-directing. The FI supports the Participant with billing and payment of goods and services and general administrative supports. | $0 |
|  | Individual Directed Goods and Services (IDGS)  IDGS are services, equipment, or supplies that are not provided through Medicaid. The service supports the Participant’s independence. | $0 |
|  | Intensive Behavioral Services (IBS)  IBS is a short-term service focused on developing behavioral management strategies to ensure health and safety and improve the Participant’s quality of life. | $0 |
|  | Live-in Caregiver  The live-in caregiver resides in the Participant’s home and provides supports to address physical, social, and emotional needs in order for the Participant to live safely and successfully in their own home. The live-in caregiver cannot be related to the Participant by blood or marriage. | $0 |
|  | Pathway to Employment  This service provides career planning and support services. Assistance is provided for the Participant to obtain, maintain, or advance in competitive employment or self-employment. | $0 |
|  | Prevocational Services  This service provides learning and work experience, including volunteering. The Participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment. | $0 |
|  | Residential Habilitation  This service includes activities or supports that are designed to help the Participant pursue or maintain outcomes in the Participant’s life that have value to the Participant. | $0 |
|  | Respite  Respite care provides relief to non-paid caregivers who provide primary care and support to the Participant.  The location for this service is the Participant’s home, but respite services may also be provided in another community dwelling or facility acceptable to the Participant. | $0 |
|  | Supported Employment (SEMP)  SEMP services provide intensive ongoing support for a Participant to obtain and maintain a job in the general workforce and to be compensated at or above the minimum wage. | $0 |
|  | Support Brokerage  This service is provided to Participants who are self-directing. The Support Broker provides assistance and skills training in the area of understanding and managing responsibilities for self-direction, community inclusion, and independent living. | $0 |
|  | Vehicle Modifications  This service includes physical changes to a Participant's vehicle, required by the Participant's Life Plan, that are necessary to ensure the health, welfare and safety of the Participant or that enable the Participant to function with greater independence. | $0 |

# Our plan’s visitor or traveler benefits

[If your plan offers a visitor/traveler program to Participants 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 name> service area for more than 6 months at a time but do not permanently move, the state and CMS will usually disenroll you from our plan. However, we offer a visitor/traveler program [specify areas where the visitor/traveler program is being offered] that will allow you to remain enrolled in <plan name> when you are outside of our service area for up to 12 months. Under our visitor/traveler program, you can get all plan-covered services at in-network cost sharing prices. You can contact <plan name> 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 <plan name> until <end date>. If you have not returned to the <plan name> service area by <end date>, you will be dropped from <plan name>.]

# Benefits covered outside of <plan name>

The following services are not covered by <plan name> but are available through Medicare or Medicaid. Your IDT will help you access these services.

## G1. Freestanding birth center services

A freestanding birth center is defined as a health facility that is not a hospital; where childbirth is planned to occur away from the pregnant woman’s residence; that is licensed or otherwise approved by the state to provide prenatal care and delivery or postpartum care and other ambulatory services.

## G2. Hospice services

Hospice services provided to Participants by Medicare approved hospice providers are paid directly by Medicare. Hospice is a coordinated program of home and inpatient care that provides non-curative medical and support services. A Participant has the right to elect hospice if his/her provider and hospice medical director determine that the Participant has a terminal prognosis. This means that the Participant has a terminal illness and is 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. Hospice programs provide Participants and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospices are organizations which must be certified under Article 40 of the New York State Public Health Law and approved by Medicare. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by Federal and State requirements. All services must be provided according to a written plan of care, which must be incorporated into the individual’s Life Plan and reflect the changing needs of the Participant/family.

If a Participant in the FIDA-IDD Plan gets hospice services, they may remain enrolled and continue to access the FIDA-IDD Plan’s benefit package. Refer to the Covered Items and Services Chart in Section D of this chapter for more information about what <plan name> pays for while you are getting hospice care services. Hospice services and services covered by Medicare Parts A and B that relate to the Participant’s terminal prognosis are paid for by Original Medicare.

**For hospice services and services covered by Medicare Part A or B that relate to a Participant’s terminal prognosis:**

* The hospice provider will bill Medicare for a Participant’s services. Medicare will pay for hospice services related to your terminal prognosis. Participants pay nothing for these services.

**For services covered by Medicare Part A or B that are not related to a Participant’s terminal prognosis:**

* The provider will bill Medicare for a Participant’s services. Medicare will pay for the services covered by Medicare Part A or B. Participants pay nothing for these services.

**For drugs that may be covered by <plan name>’s Medicare Part D benefit:**

* Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 [plan may insert reference, as applicable].

**Note:** If you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. [The plan should include a phone number or other contact information.]

# Benefits not covered by <plan name>, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by <plan name>. Excluded means that <plan name> does not pay for these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by <plan name> under any conditions and some that are excluded by <plan name> only in some cases.

<Plan name> will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Participant Handbook*) except under the 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 we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9 [plan may insert reference, as applicable].

In addition to any exclusions or limitations described in the Covered Items and Services Chart, **the following items and services are not covered by <plan name>**:

[The services listed in the remaining bullets are excluded from Medicare’s and Medicaid’s benefit packages. If any services below are required to be covered by Medicaid or under a State’s demonstration or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When a plan partially excludes services excluded by Medicare, it need not delete the item but may revise the text to describe the extent of the exclusion. The plan may add parenthetical references to the Covered Items and Services Chart for descriptions of covered services/items as appropriate. The plan may also add exclusions as needed.]

* Services considered not medically necessary according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
* Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by <plan name>. Refer to Chapter 3 [plan may insert reference, as applicable] for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
* Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.
* A private room in a hospital, except when it is medically necessary.
* Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
* Fees charged by your immediate relatives or members of your household.
* 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, <plan name> will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
* Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
* Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
* 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. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under <plan name>, we will reimburse the veteran for the difference. Participants are still responsible for their cost sharing amounts.