Chapter 3: Using the plan’s coverage for your health care and other covered services and items

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with <plan name>. It also tells you about your Care Manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). 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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# Information about “services and items,” “covered services and items,” “providers,” and “network providers”

Services and items are health care, long-term services and supports (LTSS), supplies, behavioral health, prescription and over-the-counter (OTC) drugs, equipment and other services.

Covered services and items are any of these services and items that <plan name> pays for. Covered health care and LTSS include those listed in the Covered Items and Services Chart in Chapter 4 [plan may insert reference, as applicable] and any other services that <plan name>, your IDT, or an authorized provider decides are necessary for your care.

Providers are doctors, nurses, and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you services, medical equipment, and LTSS.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you pay nothing for covered services or items.

# General rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by <plan name>

<Plan name> covers all services and items covered by Medicare and Medicaid plus some additional services and items available through the FIDA-IDD Program. These include behavioral health and LTSS.

<Plan name> will generally pay for the services and items you need if you follow plan rules for how to get them. To be covered by our plan:

* The care you get must be **a service or item covered by the** **plan.** This means that it must be included in the plan’s Covered Items and Services Chart. (The chart is in Chapter 4 [plan may insert reference, as applicable] of this handbook). Other services and items that are not listed in the chart may also be covered if your Interdisciplinary Team (IDT) determines they are necessary for you.
* The care must be **medically necessary.** Medically necessary means those services and items necessary to prevent, diagnose, correct, or cure conditions you have that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice.
* You will have an **IDT**. Your IDT will assess your needs, work with you and/or your designee to plan your care and services, and make sure that you get the necessary care and services. You can find more information about the IDT in Section C [plan may insert reference, as applicable].
  + In most cases, you must get approval from <plan name>, your IDT, or an authorized provider before you can access covered services and items. This is called prior authorization (PA). To learn more about PA, refer to page <page number>.
  + You do not need PA for emergency care or urgently needed care or to use a woman’s health provider. You can get other kinds of care without having PA. To learn more about this, refer to page <page number>.
* You will have a **Care Manager** who will serve as your primary point of contact with your IDT. You can find more information about the Care Manager in Section D [plan may insert reference, as applicable].
* You must choose a network provider to serve as your **Primary Care Provider (PCP)**. Your PCP will also be a participant of your IDT. To learn more about choosing or changing a PCP, refer to page <page number>.
* **You must get your services and items from network providers**. Usually, <plan name> will not cover services or items from a provider who has not joined <plan name>’s network. Here are some cases when this rule does not apply:
  + The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out about emergency or urgently needed care, refer to Section K, page <page number>.
  + If you need care that our plan covers, and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. To learn about getting approval to use an out-of-network provider, refer to Section E, page <page number>.
  + The plan covers services and items from out-of-network providers and pharmacies when a provider or pharmacy is not available within a reasonable distance from your home.
* The plan covers kidney dialysis services when you are outside the plan’s service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility. [Insert as applicable: The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan’s service area and obtain the dialysis from a provider that is outside the plan’s network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.]
  + When you first join the plan, you can continue using the providers you use now during the “transition period.” In most cases, the transition period will last for 90 days or until your Life Plan is finalized and implemented, whichever is later. However, your out-of-network provider must agree to provide ongoing treatment and accept payment at our rates. After the transition period, we will no longer cover your care if you continue to use out-of-network providers.
  + If you are getting services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years.
  + If you reside in an Office for People With Developmental Disabilities (OPWDD) certified residence, you can continue to get residential services from your current provider as long as you need to continue to stay there.

# Your Interdisciplinary Team (IDT)

Every Participant has an IDT. Your IDT will include the following individuals as determined by you and your FIDA-IDD Plan Care Manager:

* You and your caregiver/guardian or designee;
* Your Care Manager; **and**
* Your primary providers of developmental disability services, who have knowledge of your service needs.

Your IDT may also include the following individuals:

* Your Behavioral Health Professional, if you have one, or a designee with clinical experience from the Behavioral Health Professional’s practice who has knowledge of your needs.
* Your home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of your needs, if you are getting home care and you approve the home care aide/designee’s participation on the IDT;
* Other providers either as you or your caregiver/guardian or designee ask for or as recommended by the IDT participants as necessary for adequate care planning and approved by you or your caregiver/guardian or designee;
* Your PCP, including a physician, nurse practitioner, physician assistant, or specialist who has agreed to serve as your PCP, or a designee from your PCP’s practice who has clinical experience (such as a registered nurse, nurse practitioner, or physician assistant) and knowledge of your needs; **and**
* A clinical representative from your Intermediate Care Facility (ICF) if you get ICF care.

The FIDA-IDD Plan Care Manager is the IDT lead. Your IDT conducts your service planning and develops your Life Plan. Your IDT authorizes services in your Life Plan. These decisions cannot be changed by <plan name>. Between IDT meetings <plan name> may authorize services in addition to those services in your Life Plan.

# Your Care Manager

## D1. What a Care Manager is

The FIDA-IDD Plan’s Care Manager coordinates your IDT. The Care Manager will ensure the integration of your medical, developmental disability, behavioral health, substance use, community-based or facility-based LTSS, and social needs. The Care Manager will coordinate these services as specified in your Life Plan.

## D2. Who gets a Care Manager

All Participants have a Care Manager. Your Care Manager assignment or selection first occurs when you enroll in <plan name>.

## D3. How you can contact your Care Manager

When a Care Manager is assigned or selected, <plan name> will provide you with contact information for your Care Manager. Participant Services can also provide this information to you at any time during your participation in <plan name>.

## D4. How you can change your Care Manager

You may change your Care Manager at any time, but you will have to choose from a list of <plan name> Care Managers. If the Care Manager’s caseload permits, <plan name> must honor your request. To change Care Managers, contact Participant Services at <phone number>, <days and hours of operation>.

# Care from Primary Care Providers (PCPs), specialists, other network providers, and out-of-network providers

## E1. Care from a Primary Care Provider (PCP)

You must choose a PCP to provide and manage your care. <Plan name> will offer you the choice of at least three PCPs to select from. If you do not choose a PCP, one will be assigned to you. You can change your PCP at any time by contacting Participant Services at <toll-free number>, <days and hours of operation>.

**Definition of a “PCP,” and what a PCP does for you**

Your PCP is your main doctor and will be responsible for providing many of your preventive and primary care services. Your PCP will be a part of your IDT. Your PCP will participate in developing your Life Plan, making coverage determinations as a participant of your IDT, and recommending or asking for many of the services and items your IDT or <plan name> will authorize.

**Your choice of PCP**

We will give you a choice of at least three PCPs. If you don’t choose a PCP, we will assign one to you. In assigning a PCP to you, we will consider how far the PCP is from your home, any special health care needs you have, and any special language needs you have.

If you already have a PCP when you join the plan who does not already have an agreement with us to participate in our network, we will work with that PCP to help them join our network so you can continue to use them. However, if they refuse or are unable to join our network, you will still be able to continue using that PCP during the transition period (refer to page <page number> for more information).

**When a clinic can be your PCP**

Your PCP may not be a clinic and must be a specific type of provider that meets certain requirements. If the PCP works at a clinic and otherwise meets all criteria, that provider can be designated as a PCP.

**Option to change your PCP**

You may change your PCP for any reason, at any time. Simply call <plan name> and ask for a new PCP. The plan will process your request and tell you the effective date of the change, which will be within five business days of your request.

If your current PCP leaves our network or otherwise becomes unavailable, <plan name> will provide you with an opportunity to select a new PCP.

## E2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body.

There are many kinds of specialists. Here are a few examples:

* Oncologists care for patients with cancer.
* Cardiologists care for patients with heart problems.
* Orthopedists care for patients with bone, joint, or muscle problems.

<Plan name> or your IDT will authorize specialist visits that are appropriate for your conditions. Access to specialists must be approved by <plan name> or your IDT through a standing authorization or through pre-approval of a fixed number of visits to the specialist. This information will be included in your Life Plan.

## E3. What to do when a provider leaves our plan

[Plan may edit this section if it is obligated under state Medicaid programs to have a transition benefit when a doctor leaves the plan.]

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

* Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
* We will make a good faith effort to give you at least 15 days’ notice so that you have time to select a new provider.
* We will help you select a new qualified provider to continue managing your health care needs.
* If you are undergoing medical treatment, you have the right to ask for, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
* If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
* If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make an appeal of our decision. Refer to Chapter 9 [plans may insert a reference, as applicable] for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. [Plan should provide contact information for assistance.]

## E4. How to get care from out-of-network providers

If you need care that our plan covers and our network providers cannot give it to you, you can get permission from <plan name> or your IDT to get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. [Plan should describe the process for getting approval to use an out-of-network provider.]

Remember, when you first join the plan, you can continue using the providers you use now during the “transition period.” In most cases, the transition period will last for 90 days or until your Life Plan is finalized and implemented, whichever is later. During the transition period, our Care Manager will contact you to help you find and switch to providers that are in our network. After the transition period, we will no longer pay for your care if you continue to use out-of-network providers, unless <plan name> or your IDT has authorized you to continue using the out-of-network provider.

If you need an out-of-network provider, please work with <plan name> or your IDT to get approval to use an out-of-network provider and to find one that meets applicable Medicare or Medicaid requirements.

* If you use an out-of-network provider without first getting Plan or IDT approval, you may have to pay the full cost of the services you get.
* Providers must tell you if they are not eligible to participate in Medicare.

# Getting approval for services and items that require PA

Your IDT is responsible for authorizing all services and items that can be anticipated during the development of your Life Plan. <Plan name> and certain authorized providers are responsible for authorizing most of the health care services and items you might need in between IDT service planning meetings and Life Plan updates. These are services and items that could not have been planned or predicted and therefore were not included in your Life Plan.

## F1. Services you can get without first getting authorization

In most cases, you will need approval from <plan name>, your IDT, or certain authorized providers before using other providers. This approval is called “PA.” You can get services like the ones listed below without first getting approval:

* Emergency services from network providers or out-of-network providers.
* Urgently needed care from network providers.
* Urgently needed care from out-of-network providers when you can’t get to a network provider because you are outside the plan’s service area or you need immediate care during the weekend.

NOTE: Services must be immediately needed and medically necessary.

* Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan’s service area. (Please call Participant Services before you leave the service area. We can help you get dialysis while you are away.)
* Immunizations, including flu shots and COVID-19 vaccinations [insert if applicable: , as well as hepatitis B vaccinations and pneumonia vaccinations] [insert if applicable: , as long as you get them from a network provider].
* Routine women’s health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams [insert if applicable: as long as you get them from a network provider].
* PCP visits.
* Palliative care.
* Other preventive services.
* Services from public health agency facilities for tuberculosis screening, diagnosis and treatment, including Directly Observed Therapy (TB/DOT).
* Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
* Dental services through Article 28 clinics operated by Academic Dental Centers.
* Cardiac rehabilitation for the first course of treatment (a Physician or Registered Nurse (RN) authorization is required for courses of treatment following the first course).
* Supplemental education, wellness, and health management services.
* Additionally, if you are eligible to get services from Indian health providers, you may use these providers without approval from <plan name> or your IDT.

# How to get long-term services and supports (LTSS)

Community-based LTSS are a range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health. These services are provided in the person’s home or a community-based setting. Facility-based LTSS are services provided in an ICF or other long-term residential care setting.

As a Participant in <plan name>, you will get a comprehensive assessment of your needs, including your need for community-based or facility-based LTSS. All of your needs, as identified in your assessment, will be addressed in your Life Plan. Your Life Plan will outline which LTSS you will get, from whom, and how often.

If you have a pre-existing service plan prior to your enrollment into <plan name>, you will continue to get any community-based or facility-based LTSS included in the pre-existing plan. Your pre-existing service plan will be honored for 90 days or until your Life Plan is finalized and implemented, whichever is later.

If you have questions about LTSS, contact Participant Services or your Care Manager.

# How to get behavioral health services

[The plan may provide applicable information about getting behavioral health services, such as adding contact information for a behavioral health vendor.]

Behavioral health services are a variety of services that can support mental health and substance abuse needs you may have. This support can include emotional, social, educational, and recovery services, in addition to more traditional psychiatric or medical services.

As a Participant in <plan name>, you will get a comprehensive assessment of your needs, including your need for behavioral health services. All of your needs, as identified in your assessment, will be addressed in your Life Plan. Your Life Plan will outline which behavioral health services you will get, from whom, and how often.

If you are getting services from a behavioral health provider at the time of your enrollment in <plan name>, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in <plan name>’s network.

If you have questions about behavioral health services, contact Participant Services or your Care Manager.

# How to get self-directed care

[Plan may provide additional applicable information about what self-directed care is and how Participants can get it.]

## I1. Home and Community Based (HCBS) self-direction services

The HCBS self-direction services option is available to you if you are enrolled in OPWDD’s comprehensive HCBS waiver program. Self-direction may be right for you if you can make your own decisions (or your guardian or designee can) and are prepared to take more responsibility for managing your staff and services.

Self-direction services give you flexibility to choose the mix of supports and services that are right for you so you can **live the life you want**. With self-direction, you choose your services, the staff and organizations that provide them, and a schedule that works best for you. Self-direction empowers you to design supports based on your unique strengths and needs.

If you choose self-direction, you will get assistance and support from a Fiscal Intermediary (FI) and Support Broker. In addition, you can hire someone to assist with paperwork, training, and other staff support activities. Self-direction gives you the chance to take responsibility over the staff and services that you get.

During your IDT Meetings, your Care Manager and IDT will review the self-direction options available to you, explain which HCBS Services can be self-directed, and tell you how to get started. You can select this option at any time by contacting your Care Manager.

## I2. Consumer Directed Personal Assistance Services (CDPAS)

You have the opportunity to direct your own services through the CDPAS program.

If you are chronically ill or physically disabled and have a medical need for help with activities of daily living (ADLs) or skilled nursing services, you can get services through the CDPAS program. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. You have flexibility and freedom in choosing your caregivers.

You must be able and willing to make informed choices regarding the management of the services you get or have a legal guardian or designated relative or other adult able and willing to help make informed choices.

You or your designee must also be responsible for recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services, and keep payroll records.

Your Care Manager and IDT will review the CDPAS option with you during your IDT meetings. You can select this option at any time by contacting your Care Manager.

# How to get transportation services

<Plan name> will provide you with emergency and non-emergency transportation. Your IDT will discuss your transportation needs and will plan for how to meet them. Call your Care Manager any time you need transportation to a provider in order to get covered services and items.

Transportation coverage includes a transportation attendant to accompany you somewhere, if necessary.

Transportation is also available to non-medical events or services such as religious services, community activities, or supermarkets.

# How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

## K1. Care when you have a medical emergency

**Definition of a medical emergency**

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, you or 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 harm to bodily functions; **or**
* serious dysfunction of any bodily organ or part; **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 to that of your unborn child.

**What to do if you have a medical emergency**

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval from <plan name> or your IDT. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories [Insert as applicable: or worldwide] from any provider with an appropriate state license.
* **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. [The plan must either provide the phone number and days and hours of operation or explain where to find the number (e.g., on the back of your Participant ID Card).]

**Covered services in a medical emergency**

[If the plan covers emergency medical care outside the United States or its territories through Medicaid, it may describe this coverage based on the state Medicaid program coverage area. The plan must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]

If you need an ambulance to get to the emergency room, <plan name> covers that. We also cover medical services during the emergency. To learn more, refer to the Covered Items and Services Chart in Chapter 4 [the plan may insert reference, as applicable].

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

[The plan may modify this paragraph as needed to address their post-stabilization care.] Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

**Getting emergency care if it wasn’t an emergency after all**

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn’t really an emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was not an emergency, we will cover your additional care only if:

* you use a network provider, **or**
* the additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (Refer to the next section.)

## K2. Urgently needed care

**Definition of urgently needed care**

Urgently needed care is care you get for a situation that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

**Urgently needed care when you are in the plan’s service area**

In most situations, we will cover urgently needed care only if:

* you get this care from a network provider, **and**
* you follow the other rules described in this chapter.

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

[The plan must insert instructions for how to access urgently needed services (e.g., using urgent care centers, nurse hotline, etc.).]

**Urgently needed care when you are outside the plan’s service area**

When you are outside the plan’s service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

[If the plan covers urgently needed care outside the United States or its territories through Medicaid, it may describe this coverage based on the state Medicaid program coverage area.]

Our plan does not cover urgently needed care or any other [insert if plan covers emergency care outside of the United States and its territories: non-emergency] care that you get outside the United States.

## K3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from <plan name>.

Please visit our website for information on how to obtain needed care during a declared disaster: <web address>. [In accordance with 42 CFR 422.100(m), the plan is required to include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster’s start and end dates.]

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at [insert as applicable: the in-network cost-sharing rate **or** no cost to you].If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

# What to do if you are billed directly for services and items covered by <plan name>

Providers should not bill you directly for covered services or items. Providers should only bill <plan name> for the cost of your covered services and items. If a provider sends you a bill instead of sending it to <plan name>, you can send it to us to pay. **You should not pay the bill yourself. But if you do, it is your right to be paid back.**

If you have paid for your covered services or items, or if you have gotten a bill for covered services or items, **refer to Chapter 7** [plan may insert reference, as applicable] **to learn what to do.**

## L1. What to do if services or items are not covered by our plan

<Plan name> covers all services and items:

* that are medically necessary, **and**
* that are listed in the plan’s Covered Items and Services Chart or that your IDT determines are necessary for you (refer to Chapter 4 [the plan may insert reference, as applicable]), **and**
* that you get by following plan rules.

If you get services or items that aren’t covered by <plan name>, **you must pay the full cost yourself.**

If you want to know if we will pay for any services or items, you have the right to ask us. You also have the right to ask for this in writing. You have the right to appeal our decision.

Chapter 9 [the plan may insert reference, as applicable] explains what to do if you want the plan to cover a medical service or item. It also tells you how to appeal a coverage decision. You may also call Participant Services to learn more about your appeal rights.

If you disagree with a decision made by the plan, you may contact the Independent Consumer Advocacy Network (ICAN) to help you appeal the decision. ICAN provides free information and assistance. You can call ICAN at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800), Monday through Friday from 8:00 am to 8:00 pm.

# Coverage of health care services when you are in a clinical research study

## M1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare [if the plan conducts or covers clinical trials that are not approved by Medicare, insert: or our plan]approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from <plan name>, your IDT, or your PCP. The providers that give you care as part of the study do not need to be network providers.

[If applicable, plan should insert brief text about approval for, and voluntary participant participation in, any clinical research studies Medicaid or the plan offers.]

**We encourage you to tell us before you start participating in a clinical research study.** If you plan to be in a clinical research study, you or your Care Manager should contact Participant Services to let us know you will be in a clinical trial.

## M2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

* Room and board for a hospital stay that Medicare would pay for even if you weren’t in a study.
* An operation or other medical procedure that is part of the research study.
* Treatment of any side effects and complications of the new care.

[If the plan conducts or covers clinical trials that are not approved by Medicare insert: We will pay any costs if you volunteer for a clinical research study that Medicare does not approve but that our plan approves.] If you are part of a study that Medicare [if the plan conducts or covers clinical trials that are not approved by Medicare, insert: or our plan]has not approved, you will have to pay any costs for being in the study.

[If applicable, the plan should describe Medicaid’s role in paying for clinical research studies.]

## M3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf)). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

# How your health care services are covered when you are in a religious non-medical health care institution

[If applicable, the plan should revise this section as needed to describe Medicaid’s role in providing care in religious non-medical health care institutions.]

## N1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility (SNF). If getting care in a hospital or a SNF is against your religious beliefs, we will cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

## N2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is “non-excepted.”

* “Non-excepted” medical treatment is any care that is **voluntary and not required** by any federal, state, or local law.
* “Excepted” medical treatment is any care that is **not voluntary and is required** under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

* The facility providing the care must be certified by Medicare.
* <Plan name>’s coverage of services is limited to non-religious aspects of care.
* If you get services from this institution that are provided to you in a facility, the following applies:
  + You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  + [Omit this bullet if not applicable] You must get approval from <plan name> or your IDT before you are admitted to the facility or your stay will not be covered.

[The plan must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Covered Items and Services Chart in Chapter 4 [the plan may insert reference, as applicable]) or whether there is unlimited coverage for this benefit.]

# Durable medical equipment (DME)

## O1. Durable medical equipment (DME) as a Participant of our plan

DME includes certain items ordered by a provider 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, and walkers.

You will always own certain items that <plan name> buys for you, such as prosthetics.

In this section, we discuss DME you must rent. As a Participant of <plan name>, you [insert if the plan sometimes allows transfer of ownership: usually] will not own the rented equipment, no matter how long we rent it for you. Examples of DME items we must rent for you are wheelchairs, hospital beds, and continuous positive airway pressure (CPAP) devices.

[If the plan allows transfer of ownership of certain DME items to Participants, the plan must modify this section to explain the conditions under which and when the Participant can own specified DME.]

[If the plan sometimes allows transfer of ownership to the Participant for DME items other than prosthetics, insert: In certain limited situations, we will transfer ownership of the DME item to you. Call Participant Services to find out about the requirements you must meet and the papers you need to provide.]

Even if you had the DME item for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

[The plan should modify this section as necessary to explain any additional Medicaid coverage of DME.]

## O2. DME ownership when you lose your Medicaid coverage and switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

**Note:** You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2023* handbook. If you don’t have a copy of this booklet, you can get it at the Medicare website ([www.medicare.gov](http://www.medicare.gov)) or by calling 1‑800‑MEDICARE (1‑800‑633‑4227), 24 hours a day, 7 days a week. TTY users should call 1‑877‑486‑2048.

If you lose your Medicaid coverage and leave the FIDA-IDD Program, you will have to switch to either Original Medicare or a Medicare Advantage plan. You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

* you did not become the owner of the DME item while you were in our plan, **and**
* you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined <plan name>, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you would have to make after your Medicaid ends**.

* You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
* There are no exceptions to this when you return to Original Medicare or a Medicare Advantage plan.

## O3. Oxygen equipment benefits as a participant of our plan

If you qualify for oxygen equipment covered by Medicare and you are a participant of our plan, we will cover the following:

* Rental of oxygen equipment
* Delivery of oxygen and oxygen contents
* Tubing and related accessories for the delivery of oxygen and oxygen contents
* Maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it’s no longer medically necessary for you or if you leave our plan.

## O4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

* your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
* your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

* your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
* a new 5-year period begins.
* you will rent from a supplier for 36 months.
* your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
* a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

# How you get your Medicare and Medicaid services if you leave our FIDA-IDD Plan

If you leave our FIDA-IDD Plan, you will go back to getting your Medicare and Medicaid services separately as described below.

## P1. How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. If you choose to enroll in one of these options while you are participating in the FIDA-IDD Plan, you will automatically end your participation in <plan name>.

|  |  |
| --- | --- |
| **1. You can change to:**  **A Medicare health plan, such as a Medicare Advantage plan or a Program of All- inclusive Care for the Elderly (PACE)** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan.  If you need help or more information:   * Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. [TTY phone number is optional.]   You will automatically be disenrolled from <plan name> when your new plan’s coverage begins. |
| **2. You can change to:**  **Original Medicare with a separate Medicare prescription drug plan** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. [TTY phone number is optional.]   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |
| **3. You can change to:**  **Original Medicare without a separate Medicare prescription drug plan**  **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don’t want to join.  You should only drop prescription drug coverage if you get drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.  If you need help or more information:   * Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. [TTY phone number is optional.]   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |

## P2. How you will get Medicaid services

You will get your LTSS and your Medicaid physical and behavioral health services through Medicaid Fee-for-Service.

If you were getting services through the OPWDD comprehensive waiver while enrolled in our FIDA-IDD Plan, you will continue to get OPWDD waiver services upon your disenrollment from our plan.