Chapter 4: Covered Items and Services

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

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# Understandingyour 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 [plans may insert reference, as applicable]. [Insert if applicable: This chapter also explains limits on some services.]

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

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

# <Plan name> does not allow providers to charge 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, see Chapter 7** [plans may insert reference, as applicable] **or call Participant Services.**

# About the Covered Items and Services Chart

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

**We will pay for the 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, or threaten some significant handicap*.*
* 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 [plans may insert reference, as applicable] has more information about using network and out-of-network providers.
* You have an Interdisciplinary Team (IDT) that will arrange and manage your care. For more information on your IDT, see Chapter 3 [plans 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. The Covered Items and Services Chart tells you when an item or service does not require prior authorization.

[Insert as applicable: Most **or** All] preventive services are covered by <plan name>. You will see 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:

* For all preventive care and screening test benefit information, plans that cover a richer benefit do not need to include the given description (unless it is still applicable) and may instead describe the plan benefit.
* Plans must add the following statement to the benefit description for services that do not require prior authorization: “This service does not require prior authorization.”
* Plans must include any services provided in excess of the Medicare and Medicaid requirements where the plan has received approval from NYSDOH to provide the supplemental service(s). Preventive services must be identified with the apple icon.
* HMOPOS plan types must provide information about which services must be   
  obtained from network providers, which services can be obtained out-of-network under the POS benefit, and any differences in cost sharing for covered services obtained out-of-network under the POS benefit.
* Plans 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.
* Plans must describe within the chart any restrictive policies, limitations, or monetary limits for supplemental benefits where the plan has received approval from NYSDOH to provide the supplemental benefit(s).
* Plans may add references to the list of exclusions as appropriate. If an excluded benefit is highly similar to an allowed benefit, the plan must add an appropriate reference to the list of exclusions. If the benefit does not resemble any exclusion, then the plan should not reference the exclusion list.]

# The Covered Items and Services Chart

| Services that <plan name> pays for | | What you must pay |
| --- | --- | --- |
| Apple icon indicates preventive services. | Abdominal aortic aneurysm screening  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 |
|  | **Adult day health care**  <Plan name> will pay for adult day health carefor 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 (ADHCP) for Participants with HIV.  ADHCP includes 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 |
|  | 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 [insert as appropriate: physician **or** provider] or practitioner in a primary care setting.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $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 indicates 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 prior authorization. | $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 |
|  | Assisted living program  <Plan name> will pay for Assisted Living Program services provided in an adult home or enriched housing setting.  Services include:   * Personal care * Housekeeping * Supervision * Home health aides * Personal emergency response services * Nursing * Physical, occupational, and/or speech therapy * Medical supplies and equipment * Adult day health care * A range of home health services * Case management services of a registered professional nurse | $0 |
|  | Assistive technology  <Plan name> will pay for physical adaptations to the private residence of the Participant or the Participant’s family. The adaptations must be necessary to ensure the health, welfare, and safety of the Participant or enable the Participant to function with greater independence in the home.  Covered adaptations include:   * Installation of ramps and grab bars * Widening of doorways * Modifications of bathrooms * Installation of specialized electric and plumbing systems | $0 |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
| Apple icon indicates 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  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $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 prior authorization. | $0 |
| Apple icon indicates preventive services. | Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)  <Plan name> pays for one visit a year with your Primary care Provider (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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
|  | Care management (service coordination)  Care management is an individually designed intervention that helps the Participant get access to needed services. These care management interventions are designed to ensure the Participant’s health and welfare and increase the Participant’s independence and quality of life. | $0 |
| Apple icon indicates 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 cancer: one Pap test and pelvic exam every 12 months  For women who have had an abnormal Pap test and are of childbearing age: one Pap test and pelvic exam every 12 months  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $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  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).] | $0 |
| Apple icon indicates preventive services. | Colorectal cancer screening  <Plan name> will pay for the following:   * Barium enema   + Covered once every 48 months if you're 50 or over and once every 24 months if you're at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or 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. * DNA based colorectal screening   + Covered once every 3 years if you’re 50 or over. * Fecal occult blood test   + Covered once every 12 months if you're 50 or older. * Guaiac-based fecal occult blood test *or* fecal immunochemical test   + Covered once every 12 months if you’re 50 or over. * Flexible sigmoidoscopy   + Covered once every 48 months for most people 50 or older. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy.   [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
|  | Community integration counseling  <Plan name> will pay for community integration counseling. This is a counseling service provided to Participants who are coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others.  This service is primarily provided in the provider’s office or the Participant’s home. Community integration counseling services are usually provided in one-to-one counseling sessions. However, there are times when it is appropriate to provide this service to the Participant in a family counseling or group counseling setting. | $0 |
|  | Community transitional services  <Plan name> will pay for Community Transitional Services (CTS). These services help a Participant transition from living in a nursing facility 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 |
|  | Comprehensive Psychiatric Emergency Programs (CPEPs)  <Plan name> will pay for Office of Mental Health licensed programs that directly provide or help you get a full range of psychiatric emergency services. These services are provided 24 hours a day, seven days a week. | $0 |
|  | 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 (such as the parent of a disabled or chronically ill child) 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 |
|  | Crisis intervention services  If you are having a mental health crisis, <plan name> will pay for clinical intervention through your crisis intervention clinic. Crisis services do not need to be in your treatment plan in order to be covered.  These services may be provided by phone or in person, with some exceptions. At a minimum, each clinic will have a clinician that can help you by phone 24 hours a day, seven days a week. At the clinic's option, it may provide face-to-face crisis services 24 hours a day, seven days a week. | $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 |
|  | 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   Oral exams and cleanings require prior authorization by the plan or your IDT. 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 prior authorization. | $0 |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).] | $0 |
|  | Diagnostic testing  See “Outpatient diagnostic tests and therapeutic services and supplies” in this chart. | $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  IV infusion pumps  Speech generating devices  Oxygen equipment and supplies  Nebulizers  Walkers  Other items *may* be covered.  [Plans that do not limit the DME brands and manufacturers that you will cover, insert:We will pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.]  [Plans that limit the DME brands and manufacturers that you will cover, insert 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>.  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.  ***This benefit is continued on the next page*** | $0 |
|  | Durable medical equipment (DME) and related supplies (continued)  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, see Chapter 9 [plans 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, you or anyone with an average knowledge of health and medicine could expect it to result in:  placing your health (or, with respect to a pregnant woman, your health or that of your unborn child) in serious jeopardy, or in the case of a behavioral condition, placing your health or the health of others in serious jeopardy;  *This benefit is continued on the next page* | $0  If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, [plans should insert information as needed to accurately describe emergency care benefits:(e.g. you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the <plan name> approves your stay.)]. |
|  | Emergency care (continued)  serious harm to bodily functions; ***or***  serious dysfunction of any bodily organ or part; ***or***  serious disfigurement; ***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.   [Also identify whether the plan only covers emergency care within the U.S. and its territories as required or also covers emergency care as a supplemental benefit that provides world-wide emergency/urgent coverage.]  This service does not require prior authorization. |  |
|  | Environmental modifications and adaptive devices  <Plan name> will pay for internal and external physical adaptations 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 |
|  | [Plans should modify this as necessary.]  Family planning services  The law lets you choose any 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), 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 prior authorization.  [*For FIDA Plans that do not cover certain family planning services due to religious exemption, include:* <Plan name> does not cover certain family planning and reproductive health services, such as abortion, sterilization, and prescription birth control. New York State requires us to inform you that you can use your Medicaid card to get these services from any doctor or clinic that accepts Medicaid.] | $0 |
| Apple icon indicates 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 prior authorization. | $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.  ***This benefit is continued on the next page*** | $0 |
|  | Hearing services (continued)  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   [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).] |  |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
|  | Home and community support services (HCSS)  <Plan name> will pay for HCSS for Participants who:   * require assistance with personal care services tasks, and * whose health and welfare in the community is at risk because supervision of the Participant is required when no personal care task is being performed. | $0 |
|  | Home delivered and congregate meals  <Plan name> will pay for congregate and home delivered meals. This is an individually designed service that provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when providing such meals will decrease the need for more costly supported in-home meal preparation. This benefit includes three meals a day for 52 weeks a year. | $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  <Plan name> will pay for the administration of home infusion drugs and supplies. | $0 |
|  | Home maintenance services  <Plan name> will pay for home maintenance services. Home maintenance services include household chores and services that are required to maintain an individual’s home environment in a sanitary, safe, and viable manner. Chore services are provided on two levels:   * Light chores – Cleaning and/or washing of windows, walls, and ceilings; snow removal and/or yard work; tacking down loose rugs and/or securing tiles; and cleaning of tile work in bath and/or kitchen. Light chores are provided when needed. * Heavy-duty chores – limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Heavy-duty chore services may include (but are not limited to) tasks such as scraping and/or cleaning of floor areas. | $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 can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.  The plan will pay for the following while you are getting hospice services:  Drugs to treat symptoms and pain  Short-term respite care  Home care  ***Hospice services and services covered by Medicare Part A or B are billed to Medicare.***  See 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.  ***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 see Chapter 5 [plans 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. [Plans 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 indicates preventive services. | Immunizations  <Plan name> will pay for the following services:  Pneumonia vaccine  Flu shots, once a year, in the fall or winter  Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B  Other vaccines if you are at risk and they meet Medicare Part B coverage rules  <Plan name> will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 [plans may insert reference, as applicable] to learn more.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  These services do not require prior authorization. | $0 |
|  | Independent living skills and training  Independent Living Skills Training and Development (ILST) services are individually designed to improve or maintain the ability of the Participant to live as independently as possible in the community. ILST may be provided in the Participant’s residence and in the community.  Services may include assessment, training, and supervision of or assistance with:   * Self-care * Medication management * Task completion * Communication skills * Interpersonal skills * Socialization   *This benefit is continued on the next page* | $0 |
|  | Independent living skills and training (continued)   * Sensory/motor skills * Mobility * Community transportation skills * Reduction/elimination of maladaptive behaviors * Problem solving skills * Money management * Pre-vocational skills * Ability to maintain a household |  |
|  | 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  *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)  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.  If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. [Plans should include the following, modified as appropriate: Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If <plan name> provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.] [Plans may further define the specifics of transplant travel coverage.] |  |
|  | Inpatient mental health care  <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 |
|  | [Plans with no day limitations on a plan’s hospital or nursing facility coverage may modify or delete this row as appropriate.]  Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay  If your inpatient stay is not reasonable and needed, <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 skilled nursing facility (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 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 |
|  | 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 [plans may insert reference, as applicable]  Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care  Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments  Home dialysis equipment and supplies  Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply  **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.**  Kidney disease education services do not require prior authorization. | $0 |
| Apple icon indicates preventive services. | **Lung cancer screening**  The plan will pay for lung cancer screening every 12 months if you:   * Are aged 55-77, *and* * Have a counseling and shared decision-making visit with your doctor or other qualified provider, *and* * Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer *or* smoke now or have quit within the last 15 years.   After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.  [*List any additional benefits offered.*] | $0 |
| 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $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 |
|  | Medicare Part B prescription drugs  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  Drugs you take using durable medical equipment (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  *This benefit is continued on the next page* | $0 |
|  | Medicare Part B prescription drugs (continued)  Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)  IV immune globulin for the home treatment of primary immune deficiency diseases   * **Chapter 5** [plans may insert reference, as applicable] **explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. * **Chapter 6** [plans may insert reference, as applicable] **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** [plans 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 moving assistance services. These are individually designed services intended to move a Participant’s possessions and furnishings when the Participant must be moved from inadequate or unsafe housing to an environment which more adequately meets the Participant’s health and welfare needs and reduces the risk of unwanted nursing facility placement.  Moving assistance does not include items such as security deposits, including broker’s fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (for example, telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control, or cleaning prior to occupancy. | $0 |
|  | New York State Office of Mental Health Licensed Community Residences  <Plan name> will pay for behavioral health residential programs in these settings that provide rehabilitative and supportive services. These services focus on intensive, goal-oriented intervention, within a structured program setting, to address residents’ needs regarding community integration. These services also include goal-oriented interventions which focus on improving or maintaining resident skills to enable living in community housing. | $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 indicates 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 prior authorization. | $0 |
| Apple icon indicates 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 Primary Care Provider (PCP) to find out more.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $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  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).] | $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 observation services or outpatient surgery  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 nurse practitioner,  a physician assistant, ***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 [Plans should include any Medicaid limitations that apply (e.g., number of visits)]  Day treatment [Plans should include any Medicaid limitations that apply (e.g., number of visits)]  Psychosocial rehab services [Plans should include any Medicaid limitations that apply (e.g., number of visits)]  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  Participants may directly access one assessment from a network provider in a twelve (12) month period without getting prior authorization. | $0 |
|  | Outpatient rehabilitation services  <Plan name> will pay for Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST).  You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.  OT and ST services are limited to twenty (20) visits per therapy per calendar year, and PT services are limited to forty (40) visits per calendar year. These limits do not apply to individuals with intellectual disabilities, individuals with traumatic brain injury, and individuals under age 21. | $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 serviced do not require prior authorization. | $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 you get 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   [Network plans that do not have an in-network community mental health center may add: **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.] | $0 |
|  | Peer-delivered services  <Plan name> will pay for peer support services provided by a peer support provider. This is a person who assists individuals with their recovery from mental illness and substance abuse disorders. | $0 |
|  | Peer mentoring  <Plan name> will pay for peer mentoring for Participants who have recently transitioned into the community from a nursing facility or during times of crisis. This is an individually designed service intended to improve the Participant’s self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This will be accomplished through education, teaching, instruction, information sharing, and self-advocacy training. | $0 |
|  | Personal care services (PCS)  <Plan name> will pay for PCS 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 [plans 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 it to see whether you need treatment  [Insert if the plan has a service area and providers/locations that qualify for telehealth services under the Medicare requirements: Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for Participants in rural areas or other places approved by Medicare]  Second opinion [insert if appropriate: by another network provider] before a medical procedure  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  Participants may see PCPs without first getting prior authorization. | $0 |
|  | 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  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).] | $0 |
|  | Positive behavioral interventions and support (PBIS)  <Plan name> will pay for PBIS for Participants who have significant behavioral difficulties that jeopardize their ability to remain in the community. The primary focus of this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors.  Examples of PBIS include:  Comprehensive assessment of the Participant  Development and implementation of a holistic structured behavioral treatment plan  Training of family, natural supports, and other providers  Regular reassessment of the effectiveness of the Participant’s behavioral treatment plan | $0 |
| Apple icon indicates 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 see 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 indicates 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  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).] | $0 |
|  | Residential addiction services  <Plan name> will pay for addiction treatment services delivered by an approved residential program. | $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 |
|  | Respite care services  <Plan name> will pay for respite care services to provide scheduled relief to non-paid supports who provide primary care and support to a Participant. The service may be provided in a 24-hour block of time as required.  The primary location for this service is in the Participant’s home, but respite services may also be provided in another community dwelling or facility acceptable to the Participant. | $0 |
| Apple icon indicates 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 PCPor 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
|  | Skilled nursing facility (SNF) care  <Plan name> covers an unlimited number of days of Skilled Nursing Facility (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 needed  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 lives at the time you leave the hospital | $0 |
| Apple icon indicates 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  This service does not require prior authorization. | $0 |
|  | Social and environmental supports  <Plan name> will pay for services and items to support a Participant’s medical needs. Services may include:   * Home maintenance tasks * Homemaker/chore services * Housing improvement * Respite care | $0 |
|  | Social day care  <Plan name> will pay for social day care for functionally impaired Participants for less than 24 hours per day.  The services included in this benefit provide Participants with socialization, supervision and monitoring, personal care, and nutrition in a protective setting. | $0 |
|  | Social day care transportation  <Plan name> will pay for transportation between a Participant’s home and the social day care facilities. | $0 |
|  | Structured day program  <Plan name> will pay for structured day program services provided in an outpatient congregate setting or in the community. Services are designed to improve or maintain the Participant’s skills and ability to live as independently as possible in the community.  Services may include:   * Assessment * Training and supervision to an individual with self-care * Task completion * Communication skills * Interpersonal skills * Problem-solving skills * Socialization * Sensory/motor skills * Mobility * Community transportation skills * Reduction/elimination of maladaptive behaviors * Money management skills * Ability to maintain a household | $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. This service does not include Methadone Maintenance, which is available through Medicaid but not through <plan name>. | $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 prior authorization. | $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 |
|  | 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 prior authorization. | $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 * Livery * 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.  Urgent care does not include primary care services or services provided to treat an emergency medical condition.  [Include in-network benefits. Also identify whether this coverage is within the U.S. and its territories or is supplemental world-wide emergency/urgent coverage.]  These services do not require prior authorization. | $0 |
| Apple icon indicates preventive services. | Vision care: Eye and vision exams and eye care  <Plan name> will pay 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  Article 28 Clinic services may be directly accessed without prior authorization 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.  [Plans should modify this description if the plan 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.  [List any additional benefits offered where the plan has received approval from NYSDOH to provide the supplemental service(s).]  Article 28 Clinic services may be directly accessed without prior authorization from <plan name> or your IDT. | $0 |
| Apple icon indicates 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.  **Important:** 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 prior authorization. | $0 |

# Using 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 receiving 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, the state and CMS will usually drop you from our plan. However, we offer a visitor/traveler program [specify areas where the visitor/traveler program is being offered] that will allow you to remain enrolled in <plan name> when you are outside of our service area for up to 12 months. This program is available to all <plan name> Participants who are in a visitor/traveler area. Under our visitor/traveler program, you can get all plan-covered services at in-network cost sharing prices. You can contact <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 four services are not covered by <plan name> but are available through Medicare or Medicaid. Your Interdisciplinary Team (IDT) will help you access these services.

## Day treatment

Day treatment is a combination of diagnostic, treatment, and rehabilitative procedures that provide the services of the clinic treatment program, as well as social training, task and skill training, and socialization activities.

## Freestanding birth center services

Services at freestanding birth centers are covered by Medicaid.

## Out of network family planning services

Out of network family planning services are paid directly by Medicaid. Services include diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases, and screening for disease and pregnancy. Also included is HIV counseling and testing when provided as part of a family planning visit. Additionally, reproductive health care includes coverage of all medically necessary abortions. Fertility services are not covered.

## Methadone Maintenance Treatment Program (MMTP)

MMTP consists of drug detoxification, drug dependence counseling, and rehabilitation services, which include chemical management of the patient with methadone. This does not include opioid treatment services, which are covered by <plan name> (see the Covered Items and Services Chart above). Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services (OASAS) under Title 14 NYCRR, Part 828.

## Directly observed therapy for tuberculosis (TB)

Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to ensure patient compliance with the physician's prescribed medication regimen. While the clinical management of TB is covered under <plan name>, TB/DOT is covered by Medicaid when provided by an approved TB/DOT provider.

## 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. 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 Person-Centered Service Plan (PCSP) and reflect the changing needs of the Participant/family.

If a Participant in the FIDA Plan gets Hospice services, he or she may remain enrolled and continue to access the FIDA Plan’s benefit package. See 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*** (except for emergency care or urgently needed care):

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 see Chapter 5 [plans 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. [Plans 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. 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, see Chapter 9 [plans 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 plan-covered supplemental benefits, are required to be covered by Medicaid or under a State’s demonstration, or have become covered due to a Medicare or Medicaid change in coverage policy, delete them from this list. When plans partially exclude services excluded by Medicare, they need not delete the item but may revise the text to describe the extent of the exclusion. Plans may add parenthetical references to the Covered Items and Services Chart for descriptions of covered services/items as appropriate. Plans 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>. See Chapter 3, pages <page numbers>, 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 needed and Medicare pays for it.

A private room in a hospital, except when it is medically needed.

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 needed.

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, vision therapy, and other low-vision aids.

Reversal of sterilization procedures and non-prescription contraceptive supplies.

Acupuncture.

* 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.

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