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

[The Plan 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 [plan may insert reference, as applicable] is listed next to each cross reference throughout the handbook.]

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# About “services and items,” “covered services and items,” “providers,” and “network providers”

**Services and items** are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter 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 long-term services and supports 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 long-term services and supports.

**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 see 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 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, long-term supports and services, and prescription drugs.

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

* 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, or drugs meet accepted standards of medical practice.
* You will have an **Interdisciplinary Team (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 receive 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*. To learn more about prior authorization, see page <page number>.
  + You do not need prior authorization for emergency care or urgently needed care or to see a woman’s health provider. You can get other kinds of care without having prior authorization. To learn more about this, see 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 member of your IDT. To learn more about choosing or changing a PCP, see 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 see what *emergency* or *urgently needed care* means, see 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 see an out-of-network provider, see 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 for a short time. You can get these services at a Medicare-certified dialysis facility.
* When you first join the plan, you can continue seeing the providers you see 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 see out-of-network providers.
* If you are receiving 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 receive residential services from your current provider as long as you need to continue to stay there.

# Your Interdisciplinary Team (IDT)

Every Participant has an Interdisciplinary Team (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 receiving home care and you approve the home care aide/designee’s participation on the IDT;
* Other providers either as requested by you or your caregiver/guardian or designee; or as recommended by the IDT members as necessary for adequate care planning and approved by you or your caregiver/guardian or designee;
* Your Primary Care Provider (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 (LP). Your IDT authorizes services in your LP. These decisions cannot be changed by <plan name>. Between IDT meetings <plan name> may authorize services in addition to those services in your LP.

# Your Care Manager

## What is a Care Manager?

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

## 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>.

## How can I contact my 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>.

## How can I change my 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>.

# Getting care from Primary Care Providers, specialists, other network providers, and out-of-network providers

## Getting care from a Primary Care Provider (PCP)

You must choose a Primary Care Provider(PCP) to provide and manage your care. <Plan name> will offer you the choice of at least three Primary Care Providers 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>.

### What is a “PCP,” and what does the PCP do for you?

Your Primary Care Provider (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 Interdisciplinary Team (IDT). Your PCP will participate in developing your Life Plan, making coverage determinations as a member of your IDT, and recommending or requesting many of the services and items your IDT or <plan name> will authorize.

### How will I get aPCP?

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 see them. However, if he or she refuses or is unable to join our network, you will still be able to continue seeing that PCP during the transition period (see page <page number> for more information).

### Ca*n a* clinic be my PCP?

No. 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.

### Changing your PCP

You may change your PCP for any reason, at any time. Simply call <plan name> and request 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.

## How to get 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> oryour 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 (LP).

## What if a network provider leaves our plan?

[Plan may edit this section if they are 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.
* When possible, we will 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 request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
* 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 file an appeal of our decision.

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.]

## 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 see an out-of-network provider.]

Remember, when you first join the plan, you can continue seeing the providers you see 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 see out-of-network providers, unless <plan name> or your IDT has authorized you to continue to see the out-of-network provider.

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

# Getting approval for services and items that require prior authorization

Your Interdisciplinary Team (IDT) is responsible for authorizing all services and items that can be anticipated during the development of your Life Plan (LP). <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 LP updates. These are services and items that could not have been planned or predicted and therefore were not included in your LP.

### 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 seeing other providers. This approval is called “prior authorization.”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 network providers because you are outside the plan’s service area.
* 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 [insert if applicable: 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].
* Primary Care 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 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 receive services from Indian health providers, you may see 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 a nursing facility or other long-term residential care setting.

As a Participant in <plan name>, you will receive 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 (LP). Your LP 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 receive 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 LP 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 receive 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 (LP). Your LP will outline which behavioral health services you will get, from whom, and how often.

If you are receiving 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

**HCBS Self-Direction Services –** TheHCBS Self-Direction services option is available to you if you are enrolled in the HCBS 1915(c) 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.

You can choose if you want to have an agency assist you in managing your staff or if you’d like to manage a budget and staff on your own. Self-Direction gives you the chance to take responsibility over the staff and services that you receive.

During your IDT Meetings, Your Care Manager and Interdisciplinary Team (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.

**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 receive, 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 Interdisciplinary Team (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 Interdisciplinary Team (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

## Getting care when you have a medical emergency

### What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe   
pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, you or any prudent layperson with an average knowledge of health and medicine could expect it to result in:

* + serious risk to your health; ***or***
  + serious harm to bodily functions; ***or***
  + serious dysfunction of any bodily organ or part; ***or***
  + if you are a pregnant woman, in active labor, meaning labor at a time when either of the following would occur:
  + There is not enough time to safely transfer you to another hospital before delivery.
  + The transfer may pose a threat to the health or safety of you or your unborn child.

### What should you 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.
* **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.

### 

### What is covered if you have 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.]

[The Plan may modify the following sentence to identify whether this coverage is within the United States and its territories or world-wide emergency/urgent coverage:]You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, <plan name> covers that. To learn more, see the Covered Items and Services Chart in Chapter 4 [the plan may insert reference, as applicable].

If you have an emergency, your Care Manager will talk with the doctors who give you emergency care. Those doctors will tell your Care Manager when your medical emergency is over.

[The Plan may modify this paragraph as needed to address the post-stabilization care for your plan.] After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by <plan name>. If you get your emergency care from out-of-network providers, your Care Manager will try to get network providers to take over your care as soon as possible.

### What if it wasn’t a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn’t really a medical 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 go to a network provider, ***or***
* the additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (See the next section.)

## Getting urgently needed care

### What is urgently needed care?

*Urgently needed care* is care you get for a sudden illness, injury, or condition that isn’t an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

###### Getting 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 you can’t 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.).]

###### Getting urgently needed care when you are outside the plan’s service area

When you are outside the 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.

## Getting 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 prior authorization; terms and conditions of payment for non-contracted providers; and each declared disaster’s start and end dates.*]

During a declared disaster, 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 see Chapter 5 for more information.

# What if you are billed directly for the full cost of 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, <plan name> may pay you back.

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

## What should you 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 Interdisciplinary Team (IDT) determines are necessary for you (see 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.

# How are your health care services covered when you are in a clinical research study?

## What is 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. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

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, someone who works on the study will contact you. That person will tell you about the study and see 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 a Medicare-approved clinical research study, you do *not* need to get approval from <plan name>, your IDT, or your Primary Care Provider. The providers that give you care as part of the study do *not* need to be network providers.

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

**You do need to tell us before you start participating in a clinical research study.**   
Here’s why:

* We can tell you if the clinical research study is Medicare-approved.

We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Care Manager should contact Participant Services to tell us.

## When you are in a clinical research study, who pays for what?

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.]

## Learning more

You can learn more about joining a clinical research study by reading “Medicare & Clinical Research Studies” on the Medicare website (<http://www.medicare.gov/publications/pubs/pdf/02226.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 are your health care services 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.]

## What is 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. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

## What care from a religious non-medical health care institution is covered by our plan?

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.
* <Plan name> will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.
* 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 Benefits Chart in Chapter 4 [the plan may insert reference, as applicable]) or whether there is unlimited coverage for this benefit.]

# Rules for owning durable medical equipment

## Will you own your durable medical equipment?

[If the Plan furnishes ownership of certain DME items, it must modify this section to explain the conditions under which and when specified DME can be owned by the member. The Plan should modify this section as necessary to explain additional Medicaid coverage of DME.]

*Durable medical equipment* means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. Other types of durable medical equipment will be rented for you by <plan name>. Examples of items that must be rented are wheelchairs, hospital beds, and continuous positive airway pressure (CPAP) devices.

[This first sentence must be inserted even if the plan sometimes allows ownership for items other than prosthetics:] In Medicare, people who rent certain types of durable medical equipment own it after 13 months. As a member of <plan name>, however, you [insert if the plan sometimes allows ownership: usually] will not own the rented equipment, no matter how long it is rented for you.

[If the plan sometimes allows ownership for items other than prosthetics, insert: In certain situations, we will transfer ownership of the durable medical equipment item. Call Participant Services to find out about the requirements you must meet and the papers you need to provide.] [If your plan never transfers ownership (except as noted above, for example, for prosthetics), insert:Even if you had the durable medical equipment for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.]

## What happens if you lose your Medicaid coverage?

If you lose your Medicaid coverage and leave the FIDA-IDD Program, you will have to make 13 payments in a row under Original Medicare to own the equipment if:

* you did not become the owner of the durable medical equipment item while you were in our plan ***and***

you get your Medicare benefits in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined <plan name>, those Medicare payments do not count toward the 13 payments you would have to make after your Medicaid ends. You will have to make 13 new payments in a row under Original Medicare to own the item.

* There are no exceptions to this case when you return to Original Medicare. If you join a Medicare health plan (such as a Medicare Advantage plan) instead of Original Medicare, you should check with the plan about its coverage of durable medical equipment.

# If you leave our FIDA-IDD Plan, how do you get your Medicare and Medicaid services?

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

## 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** | **Here is what to do:**  Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven 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.   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, seven 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.   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 an employer, union or other source. 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, seven 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.   You will automatically be disenrolled from <plan name> when your Original Medicare coverage begins. |

## How you will get Medicaid services

You will receive your long-term services and supports and your Medicaid physical and behavioral health services through Medicaid Fee-for-Service.

If you were receiving services through the OPWDD 1915(c) waiver prior to enrolling in our FIDA-IDD Plan, you will continue to receive OPWDD 1915(c) waivered services upon your disenrollment from our plan.