PHP

PARTNERS HEALTH PLAN

Your Plan
YOUR WAY

PHP Care Complete FIDA-IDD Plan
(Medicare - Medicaid Plan)

2024 PARTICIPANT HANDBOOK

Partners Health Plan is a managed care plan that contracts with Medicare, the New York State Department of Health (Medicaid) to provide benefits to Participants through the Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration.

If you have questions, please call PHP Care Complete FIDA-IDD Plan Participant Services at (855) 747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week. This call is free.

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H9869_2024_Participant Handbook

PHP Care Complete FIDA-IDD Plan *Participant Handbook*

January 1, 2024 – December 31, 2024

Your Health and Drug Coverage under PHP Care Complete FIDA-IDD Plan

Participant Handbook Introduction

This handbook tells you about your coverage under PHP Care Complete FIDA-IDD Plan (Medicare-Medicaid Plan) from the date you are enrolled with PHP Care Complete FIDA-IDD Plan through December 31, 2024. It explains how PHP Care Complete FIDA-IDD Plan covers Medicare and Medicaid services, including prescription drug coverage, at no cost to you. It explains the health care services, developmental disability services, behavioral health services, prescription drugs, and long-term services and supports (LTSS) that PHP Care Complete FIDA-IDD Plan covers.

LTSS include long-term facility-based care and long-term community-based services and supports. Long-term community-based services and supports provide the care you need at home and in your community and can help reduce your chances of going to a nursing facility or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

This is an important legal document. Please keep it in a safe place.

PHP Care Complete FIDA-IDD Plan (is a Fully Integrated Duals Advantage for Individuals With Intellectual and Developmental Disabilities (FIDA-IDD) Plan that is offered by *Partners Health Plan.* When this *Participant Handbook* says “we,” “us,” or “our,” it means *Partners Health Plan*. When it says “the plan” or “our plan,” it means PHP Care Complete FIDA-IDD Plan.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call *1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week*. The call is free.

Si usted habla español, se encuentran disponibles para usted servicios sin cargo de asistencia con el idioma. Llame al 1-855-747-5483 y al 711 para los usuarios de TTY de 8:00 a. m. a 8:00 p. m., los siete días de la semana. La llamada es gratuita.

Если Вы говорите на русском языке, Вам доступна бесплатная языковая поддержка. Звоните по телефону 1-855-747-5483 и 711 для пользователей линии TTY/TDD с 08:00 до 20:00, без выходных. Звонок бесплатный.

如果您說中文，您可以獲得免費的語言協助服務。請致電 1-855-747-5483，TTY 使用者請致電 711，服務時間為每週七天，上午 8 時至晚上 8 時。本電話為免付費電話。

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- If you would like to make or change a standing request for a preferred language or format, call PHP Care Complete FIDA-IDD Plan Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week and we will keep this on file for future mailings and communications. If we do not receive a request for a preferred language or format, we will provide you with your materials in English

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Chapter 1: Getting started as a Participant

Introduction

This chapter includes information about PHP Care Complete FIDA-IDD Plan, a health plan that covers all your Medicare and Medicaid services, and your participation in it. It also tells you what to expect and what other information you will get from PHP Care Complete FIDA-IDD Plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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A. Welcome to PHP Care Complete FIDA-IDD Plan

PHP Care Complete FIDA-IDD Plan is a Fully Integrated Duals Advantage for individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Plan. A FIDA-IDD Plan is an organization made up of doctors, hospitals, pharmacies, developmental disability providers, providers of long-term services and supports (LTSS), and other providers. It also has Care Managers and Interdisciplinary Teams (IDTs) to help you manage all your providers and services. They all work together to provide the care you need.

PHP Care Complete FIDA-IDD Plan was approved by New York State and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the FIDA-IDD Demonstration.

FIDA-IDD is a demonstration program jointly run by New York State and the federal government to provide better health care for individuals with intellectual and developmental disabilities and who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

B. Information about Medicare and Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medicaid

Medicaid is a program run by the federal government and New York State that helps people with limited incomes and resources pay for LTSS and medical costs. It covers extra services and drugs not covered by Medicare. In New York, Medicaid is called New York Medicaid.

Each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**

- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules. Specialized developmental disability services are available to individuals who are deemed eligible for services authorized by the Office for People With Developmental Disabilities (OPWDD).

Medicare and New York State must approve PHP Care Complete FIDA-IDD Plan each year. You can get Medicare and Medicaid services through our plan as long as:

- you are eligible to participate in the FIDA-IDD Demonstration,
- we choose to offer the FIDA-IDD Plan, **and**
- Medicare and New York State approve PHP Care Complete FIDA-IDD Plan to participate in the FIDA-IDD Demonstration.

If at any time our plan stops operating, your eligibility for Medicare and Medicaid services will not be affected.

C. Advantages of this FIDA-IDD Plan

In the FIDA-IDD Demonstration, you will get all your covered Medicare and Medicaid services from PHP Care Complete FIDA-IDD Plan, including LTSS and prescription drugs. **You do not pay anything to join or get services from this plan**. However, if you have Medicaid with a "spend-down" or "excess income," you will have to continue to pay your spend-down to the FIDA-IDD Plan.

PHP Care Complete FIDA-IDD Plan will help make your Medicare and Medicaid benefits work better together and work better for you. Here are some of the advantages of having PHP Care Complete FIDA-IDD Plan:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have an IDT that you help put together.
    - An IDT is a group of people that will get to know your needs and work with you to develop and carry out a Life Plan specific to your needs.
    - Your IDT will include your Care Manager, your primary provider(s) of developmental disability services, and other health professionals who are there to help you get the care you need.

- You will have a Care Manager. This person works with you, with PHP Care Complete FIDA-IDD Plan, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your IDT and your Care Manager.
- The IDT and Care Manager will work with you to come up with a Life Plan specifically designed to meet your needs. The IDT will be in charge of coordinating the services you need. This means, for example:
  - Your IDT will assist you to get the community-based services you need to live in the community.
  - Your IDT will make sure your doctors know about all medicines you take so they can reduce side effects.
  - Your IDT will make sure your test results are shared with all your doctors and other providers.
  - Your IDT will help you schedule and get appointments with doctors and other providers.

D. PHP Care Complete FIDA-IDD Plan's' service area

Our service area includes these counties in New York State: Bronx, Kings/Brooklyn, Nassau, Manhattan, Queens, Richmond/Staten Island, Rockland, Suffolk, and Westchester.

Only people who live in our service area can join PHP Care Complete FIDA-IDD Plan

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8 for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan Participant

You are eligible for our plan as long as:

- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it);
- you are entitled to Medicare Part A, enrolled in Medicare Part B, and eligible for Medicare Part D;

- you are eligible for Medicaid;
- you are a United States citizen or are lawfully present in the United States;
- you are age 21 or older at the time of enrollment;
- you are eligible for OPWDD services in accordance with New York State Mental Hygiene Law 1.03(22);
- you have been determined to be eligible for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) level of care;
- if you are getting waiver services as an alternative to ICF-IID placement, you are enrolled in the OPWDD Comprehensive Waiver; **and**
- you are not excluded from enrollment based on one of the exclusions listed below.

You will be excluded from joining our plan if:

- you are a resident of a New York State (NYS) Office of Mental Health (OMH) facility;
- you are a resident of a Skilled Nursing Facility (SNF)/Nursing Facility (NF). Upon leaving the SNF/NF, an individual with I/DD is then eligible for the FIDA-IDD Demonstration or Medicaid Fee-for-Service. A FIDA-IDD Participant who after enrolling in the FIDA-IDD Demonstration subsequently requires placement in a SNF/NF will remain in the FIDA-IDD Demonstration.
- you are a resident of a Developmental Center. Upon leaving the Developmental Center an individual with I/DD is then eligible for the FIDA-IDD Demonstration or Medicaid Fee-for-Service. A FIDA-IDD Participant, who after enrolling in the FIDA-IDD Demonstration subsequently remains continuously in a Developmental Center for more than 90 days, will be disenrolled effective the first of the next month.
- you are under the age of 21;
- you are a resident of a psychiatric facility;
- you are expected to be Medicaid eligible for less than six months;
- you are eligible for Medicaid benefits only with respect to tuberculosis-related services;

- you are an individual with a "county of fiscal responsibility" code 99 (individuals eligible only for breast and cervical cancer services);
- you are getting hospice services (at time of enrollment);
- you are an individual with a "county of fiscal responsibility" code of 97 (individuals residing in an NYS OMH facility);
- you are eligible for the family planning expansion program;
- you are under 65 years of age (screened and require treatment) in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program, need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage;
- you are a resident of an alcohol/substance abuse long-term residential treatment program;
- you are eligible for Emergency Medicaid only;
- you are enrolled in a Section 1915(c) waiver other than the OPWDD Comprehensive Waiver. Individuals enrolled in the following Section 1915(c) waivers programs are not eligible to participate in the FIDA-IDD Demonstration:
    - Traumatic Brain Injury (TBI)
    - Nursing Home Transition and Diversion (NHTD) Waiver
    - Long-Term Home Health Care Waiver
- you are a resident of an Assisted Living Program (ALP); **or**
- you are in the Foster Family Care Demonstration.

F. What to expect when you first join the FIDA-IDD Plan

When you first join the plan, you will get a comprehensive assessment of your needs within the first 30 days. The assessment will be conducted by your Care Manager from PHP Care Complete FIDA-IDD Plan.

You can keep using the doctors you use now and getting your current services for a certain amount of time. This is called 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, you may choose to begin getting services according to your approved Life Plan prior to 90 days.

Unless PHP Care Complete FIDA-IDD Plan or your IDT decides otherwise, after the transition period, you will need to use doctors and other providers in the PHP Care Complete FIDA-IDD Plan network. A network provider is a provider who works with PHP Care Complete FIDA-IDD Plan. Refer to Chapter 3, for more information on getting care.

There are two exceptions to the transition period described above:

- If you are getting services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in PHP Care Complete FIDA-IDD Plan's network.
- If you reside in an OPWDD certified residence, you can continue to get residential services from your current provider as long as your Life Plan continues to describe the need for the service.

G. Your Life Plan

After PHP Care Complete FIDA-IDD Plan's Care Manager conducts the comprehensive assessment, you will meet with the members of your IDT to talk about your needs and develop your Life Plan. Your Life Plan is the plan for what health services, LTSS, prescription drugs and social needs you will get and how you will get them.

You will have a comprehensive re-assessment when necessary, but at least once annually after the initial assessment completion date. Within 30 calendar days of the comprehensive re-assessment, your IDT will work with you to update your Life Plan. At any time during the year, you may ask for a new assessment or an update to your Life Plan by calling your Care Manager.

H. PHP Care Complete FIDA-IDD Plan monthly plan premium

There is no monthly plan premium and there are no other costs for participating in PHP Care Complete FIDA-IDD. However, if you have Medicaid with a "spend-down" or "excess income," you will have to continue to pay your spend-down to the FIDA-IDD Plan.

I. The Participant Handbook

This *Participant Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9, call 1-800-MEDICARE (1-800-633-4227), or call the Independent Consumer Advocacy Network at 1-844-614-

8800 (TTY users call 711). You may also complain about the quality of the services we provide by calling Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

You can ask for a *Participant Handbook* by calling Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week. You can also refer to the *Participant Handbook* at www.phpcares.org or download it from this website.

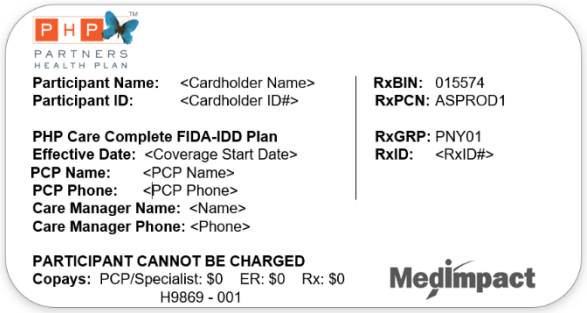
The contract is in effect for the months you are enrolled in PHP Care Complete FIDA-IDD between January 1, 2024 and December 31, 2024.

J. Other important information you will get from us

You should have already gotten a PHP Care Complete FIDA-IDD Plan Participant ID Card, instructions on how to access the *Provider and Pharmacy Directory* online or have a copy mailed to you, and *information about how to access* a *List of Covered Drugs* (Drug List).

J1. Your PHP Care Complete FIDA-IDD Plan Participant ID Card

Under our plan, you will have one card for your Medicare and Medicaid services, including LTSS and prescriptions. You must show this card when you get any services or prescriptions. Here is a sample card to show you what yours will look like:


PHP PARTNERS HEALTH PLAN

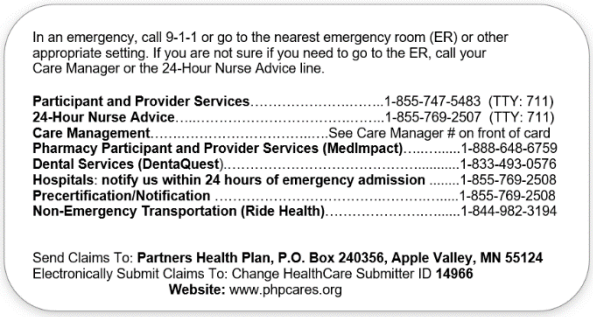
Participant Name: <Cardholder Name>
Participant ID: <Cardholder ID#>

PHP Care Complete FIDA-IDD Plan
Effective Date: <Coverage Start Date>
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>
Care Manager Name: <Name>
Care Manager Phone: <Phone>

RxBIN: 015574
RxPCN: ASPROD1
RxGRP: PNY01
RxID: <RxID#>

PARTICIPANT CANNOT BE CHARGED
Copays: PCP/Specialist: $0 ER: $0 Rx: $0
H9869 - 001

Medimpact


In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your Care Manager or the 24-Hour Nurse Advice line.

Participant and Provider Services.....1-855-747-5483 (TTY: 711)
24-Hour Nurse Advice.....1-855-769-2507 (TTY: 711)
Care Management.....See Care Manager # on front of card
Pharmacy Participant and Provider Services (MedImpact).....1-888-648-6759
Dental Services (DentaQuest).....1-833-493-0576
Hospitals: notify us within 24 hours of emergency admission.....1-855-769-2508
Precertification/Notification.....1-855-769-2508
Non-Emergency Transportation (Ride Health).....1-844-982-3194

Send Claims To: **Partners Health Plan, P.O. Box 240356, Apple Valley, MN 55124**
Electronically Submit Claims To: Change HealthCare Submitter ID **14966**
Website: www.phpcares.org

If your card is damaged, lost or stolen, call Participant Services right away and we will send you a new card.

As long as you are a Participant of our plan, you do not need to use your red, white, and blue Medicare card or your Medicaid card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your PHP Care Complete FIDA-IDD Plan Participant ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* is a list of the providers and pharmacies in the PHP Care Complete FIDA-IDD Plan network. While you are a Participant of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (refer to page 9).

There are also some exceptions if you cannot find a provider in our plan who can meet your needs. You will need to discuss this with your IDT.

- You can call Participant Services and ask them to mail you a copy of the *Provider and Pharmacy Directory* (electronically or in hard copy form). Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days.
- You can also refer to the *Provider and Pharmacy Directory* at www.phpcares.org or download it from this website.

Both Participant Services and the website can give you the most up-to-date information about changes in our network providers.

Definition of network providers

- PHP Care Complete FIDA-IDD Plan's network providers are:
    - specialized developmental disability service providers;
    - doctors, nurses, health care professionals, and other providers that you can use as a Participant of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers have agreed to accept payment from our plan for covered services as payment in full. By using these providers, you will not have to pay anything for covered services.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan Participants. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. There are no costs to you when you get prescriptions from network pharmacies.

Call Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week for more information. Both Participant Services and PHP Care Complete FIDA-IDD Plan's website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by PHP Care Complete FIDA-IDD Plan.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5 for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit www.phpcares.org or call 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

J4. The *Explanation of Benefits*

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (or EOB).

The EOB tells you the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Participant Services.

K. How to keep your Participant record up to date

You can keep your Participant record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your Participant record to know what services and drugs you get.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- changes to your name, your address, or your phone number

- changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- any liability claims, such as claims from an automobile accident
- admissions to a nursing facility or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- changes in who your caregiver (or anyone responsible for you) is
- you are part of or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any information changes, please let us know by calling Participant Services at at1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

K1. Privacy of personal health information (PHI)

The information in your Participant record may include PHI. Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your personal PHI, refer to Chapter 8.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about PHP Care Complete FIDA-IDD Plan and your health care benefits. You can also use this chapter to get information about how to contact your Care Manager and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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A. How to contact PHP Care Complete FIDA-IDD Plan Participant Services

CALL	1-855-747-5483 This call is free. 8AM to 8PM, seven days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. *This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.* 8AM to 8PM, seven days a week
FAX	*1-844-566-8296*
WRITE	Partners Health Plan 2500 Halsey Street Bronx, NY 10461
WEBSITE	*www.phpcares.org*

A1. When to contact Participant Services

- questions about the plan
- questions about claims, billing or Participant ID Cards
- coverage decisions about your services and items
  - A coverage decision is a decision about
    - whether you can get certain covered services and items **or**
    - how much you can have of certain covered services and items.
  - Call us or your Care Manager if you have questions about a coverage decision PHP Care Complete FIDA-IDD Plan or your Interdisciplinary Team (IDT) made about your services and items.
  - To learn more about coverage decisions, refer to Chapter 9

- appeals about your services and items
    - An appeal is a formal way of asking us to review a decision we or your IDT made about your coverage and asking us to change it if you think we or your IDT made a mistake.
    - To learn more about making an appeal, refer to Chapter 9.
- grievances about your services and items
    - You can file a grievance (also called “making a complaint”) about us or any provider (including a non-network or network provider). A network provider is a provider who works with PHP Care Complete FIDA-IDD Plan. You can also file a grievance about the quality of the care you got to us or to the Quality Improvement Organization (QIO) refer to Section G below.
    - Note: If you disagree with a coverage decision that PHP Care Complete FIDA-IDD Plan or your IDT made about your services or items, you can file an appeal (refer to the section above.
    - You can also send a grievance about PHP Care Complete FIDA-IDD Plan right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
    - To learn more about filing a grievance, refer to Chapter 9.
- coverage decisions about your drugs
    - A coverage decision is a decision about:
        - whether you can get certain covered drugs **or**
        - how much you can have of a certain covered drug.
    - This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs as covered by PHP Care Complete FIDA-IDD Plan. Refer to Chapter 5 and the *List of Covered Drugs* (Drug List) for more information on your drug benefits and how to get covered drugs.
    - For more on coverage decisions about your prescription drugs, refer to Chapter 9.
- appeals about your drugs

- An appeal is a way to ask us to change a coverage decision.
- *To appeal a decision on a drug, please call MedImpact Pharmacy Member Services at 1-888-648-6759, or speak to your Care Manager. The List of Covered Drugs detail that Medicare Part D drugs are Tier 1 (Generic Drugs) or Tier 2 (Brand Drugs). Medicaid drugs are listed as a Tier 3 drug.*
- For more on making an appeal about your prescription drugs, refer to Chapter 9.

- grievances about your drugs
  - You can file a grievance (also called “making a complaint”) about us or any pharmacy. This includes a grievance about your prescription drugs.
  - **Note:** If you disagree with a coverage decision about your prescription drugs, you can file an appeal (Refer to the section).
  - You can also send a grievance about PHP Care Complete FIDA-IDD Plan right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on filing a grievance about your prescription drugs, refer to Chapter 9.
- payment for health care or drugs you already paid for

  To learn how to ask us to pay you back, refer to Chapter 7.

B. How to contact your Care Manager

When you join PHP Care Complete FIDA-IDD Plan, you will be assigned a Care Manager, who will assist you in the coordination of your care and services. The name and phone number of your Care Manager is on the front of your Participant ID Card. If you do not have an ID card, you can call Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week. You are allowed to change your Care Manager, if you wish to do so please call Participant Services.

CALL	1-855-747-5483 This call is free. 8AM to 8PM, seven days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. *This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.* 8AM to 8PM, seven days a week
WRITE	Partners Health Plan 2500 Halsey Street Bronx, NY 10461
WEBSITE	www.phpcares.org

B1. When to contact your Care Manager

- questions about your care and covered services, items, and drugs
- assistance in making and getting to appointments
- questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)
- asking for services, items, and drugs
- asking for a Comprehensive Reassessment or changes to a Life Plan

C. How to contact the Nurse Advice Call Line

PHP Care Complete FIDA-IDD Plan operates a toll-free nursing hotline with live nurses available to answer health-related questions twenty-four (24) hours a day, seven (7) days a week.

Our nurses provide general health-related information as well as assistance in accessing services outside of normal business hours.

CALL	1-855-769-2507 This call is free. The Nurse Advice Call Line is available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. *This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.* The Nurse Advice Call Line is available 24 hours a day, 7 days a week.

C1. When to contact the Nurse Advice Call Line

- immediate questions about your health

D. How to contact New York Medicaid Choice

New York Medicaid Choice is New York State's enrollment broker for the FIDA-IDD program. New York Medicaid Choice can help you enroll or disenroll in the FIDA-IDD Plan. New York Medicaid Choice counselors can also help you understand your rights.

New York Medicaid Choice is not connected with any insurance company, managed care plan, or this FIDA-IDD Plan.

CALL	1-844-343-2433 This call is free. New York Medicaid Choice is available Monday through Friday from 8:30 a.m. to 8:00 p.m., and Saturday from 10:00 a.m. to 6:00 p.m.
TTY	1-888-329-1541 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	New York Medicaid Choice P.O. Box 5081 New York, NY 10274
WEBSITE	www.nymedicaidchoice.com

E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In New York State, the SHIP is called the Health Insurance Information, Counseling, and Assistance Program (HIICAP).

HIICAP is not connected with any insurance company, managed care plan, or FIDA-IDD Plan.

CALL	1-800-701-0501 This call is free.
WEBSITE	aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

You may also contact your local HIICAP office directly:

LOCAL OFFICE	CALL	WRITE
Nassau County	516-485-3754	Family and Children's Association 400 Oak Street, Suite 104 Garden City, New York 11530
New York City	212-602-4180	Department for the Aging 2 Lafayette Street, 7th Floor New York, NY 10007-1392
Rockland County	845-364-2118	Rockland County Office for the Aging 50 Sanatorium Rd, Building B Pomona, NY 10970-0350
Suffolk County	631-979-9490 Ext.14	RSVP Suffolk 811 West Jericho Turnpike, Suite 103W Smithtown, NY 11787

LOCAL OFFICE	CALL	WRITE
Westchester County	914-813-6100	Department of Senior Programs 9 South First Avenue, 10th Floor Mt. Vernon, NY 10550

E1. When to contact HIICAP

- questions about your Medicare health insurance
    - HIICAP counselors can answer your questions about changing to a new Medicare plan and help you:
        - understand your rights **and**
        - understand your Medicare plan choices.

F. How to contact the Quality Improvement Organization (QIO)

Our state has a QIO called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our plan.

CALL	1-866-815-5440 This call is free.
TTY	*1-866-868-2289* *This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.*
WRITE	Livanta QIO 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

F1. When to contact Livanta

- questions about your health care
    - You can make a complaint about the care you got if you:
        - have a problem with the quality of care,
        - think your hospital stay is ending too soon, **or**
        - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Medicaid

Medicaid helps with medical and LTSS costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the Medicaid Helpline.

CALL	1-800-541-2831 This call is free. The Medicaid Helpline is available Monday through Friday from 8:00 a.m. to 8:00 p.m. and Saturday from 9:00 a.m. to 1:00 p.m.
TTY	1-877-898-5849 This call is free. *This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.*

I. How to contact the Independent Consumer Advocacy Network (ICAN)

ICAN helps people enrolled in the FIDA-IDD Plan and works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. ICAN also helps people enrolled in Medicaid with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-844-614-8800 This call is free. ICAN is available Monday through Friday from 8:00 a.m. to 8:00 p.m.
TTY	Call 711, then follow the prompts to dial 844-614-8800
EMAIL	ican@cssny.org
WEBSITE	icannys.org

J. How to contact the New York State Long-Term Care Ombudsman

The Long-Term Care Ombudsman Program is an ombudsman program that helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and residents or their families.

CALL	1-800-342-9871 This call is free.
WEBSITE	www.ltcombudsman.ny.gov

You may also contact your local long-term care ombudsman directly. You can find the contact information for the ombudsman in your county at the following website: www.aging.ny.gov/locationsearch/ombudsmen.

K. How to contact the Office for People With Developmental Disabilities (OPWDD) and the Developmental Disabilities Regional Offices (DDROs)

OPWDD provides supports and services for individuals with intellectual and developmental disabilities. If you have questions about OPWDD services, you may contact your local DDRO or call the information line.

DDROs

- If you live in Bronx or New York (Manhattan) County, call 1-646-766-3466
- If you live in Kings County, call 1-718-642-6000
- If you live in Queens County, call 1-718-217-4242
- If you live in Richmond County, call 1-718-983-5200
- If you live in Nassau or Suffolk County, call 1-631-434-6100
- If you live in Rockland or Westchester, call 1-845-947-6100

OPWDD Toll-Free Information Line 1-866-946-9733

- For individuals with hearing impairment, use NY Relay System 711

L. Other resources

L1. Willowbrook class members

If you are a Willowbrook class member, you may be co-represented or fully represented by the Consumer Advisory Board (CAB). As a class member, you may choose to have co-representation from a family member or the CAB or you may have your family act as your full representative. While your family may be the full representative, you may also want CAB to act as co-representative. You can also be your own self-advocate and act as your own correspondent.

For more information call: 518-473-6026

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with PHP Care Complete FIDA-IDD Plan. It also tells you about your Care Manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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A. Information about "services and items," "covered services and items," "providers," and "network providers"

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

Covered services and items are any of these services and items that PHP Care Complete FIDA-IDD Plan pays for. Covered health care and LTSS include those listed in the Covered Items and Services Chart in Chapter 4, Section D and any other services that PHP Care Complete FIDA-IDD Plan, your IDT, or an authorized provider decides are necessary for your care.

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

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

B. General rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by PHP Care Complete FIDA-IDD Plan

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

PHP Care Complete FIDA-IDD Plan will generally pay for the services and items you need if you follow plan rules for how to get them. To be covered by our plan:

- The care you get must be **a service or item covered by the plan**. This means that it must be included in the plan's Covered Items and Services Chart. (The chart is in Chapter 4, Section D of this handbook). Other services and items that are not listed in the chart may also be covered if your Interdisciplinary Team (IDT) determines they are necessary for you.
- The care must be **medically necessary**. Medically necessary means those services and items necessary to prevent, diagnose, correct, or cure conditions you have that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. This includes care that keeps you from going into a hospital or nursing

facility. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice.

- You will have an **IDT**. Your IDT will assess your needs, work with you and/or your designee to plan your care and services, and make sure that you get the necessary care and services. You can find more information about the IDT in Section C.
    - In most cases, you must get approval from PHP Care Complete FIDA-IDD Plan, your IDT, or an authorized provider before you can access covered services and items. This is called prior authorization (PA). To learn more about PA, refer to page 55.
    - You do not need PA for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having PA. To learn more about this, refer to pages 55 and 56.
- 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 below
- You must choose a network provider to serve as your **Primary Care Provider (PCP)**. Your PCP will also be a participant of your IDT. To learn more about choosing or changing a PCP, refer to page 53.
- **You must get your services and items from network providers.** Usually, PHP Care Complete FIDA-IDD Plan will not cover services or items from a provider who has not joined PHP Care Complete FIDA-IDD Plan's network. Here are some cases when this rule does not apply:
    - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out about emergency or urgently needed care, refer to Section K, pages 55 – 56.
    - If you need care that our plan covers, and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. To learn about getting approval to use an out-of-network provider, refer to Section E, pages 55.
    - The plan covers services and items from out-of-network providers and pharmacies when a provider or pharmacy is not available within a reasonable distance from your home.

- The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
- When you first join the plan, you can continue using the providers you use now during the "transition period." In most cases, the transition period will last for 90 days or until your Life Plan is finalized and implemented, whichever is later. However, your out-of-network provider must agree to provide ongoing treatment and accept payment at our rates. After the transition period, we will no longer cover your care if you continue to use out-of-network providers.
- If you are getting services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years.
- If you reside in an Office for People With Developmental Disabilities (OPWDD) certified residence, you can continue to get residential services from your current provider as long as you need to continue to stay there.

C. Your Interdisciplinary Team (IDT)

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

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

Your IDT may also include the following individuals:

- Your Behavioral Health Professional, if you have one, or a designee with clinical experience from the Behavioral Health Professional's practice who has knowledge of your needs.
- Your home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of your needs, if you are getting home care and you approve the home care aide/designee's participation on the IDT;

- Other providers either as you or your caregiver/guardian or designee ask for or as recommended by the IDT participants as necessary for adequate care planning and approved by you or your caregiver/guardian or designee;
- Your PCP, including a physician, nurse practitioner, physician assistant, or specialist who has agreed to serve as your PCP, or a designee from your PCP's practice who has clinical experience (such as a registered nurse, nurse practitioner, or physician assistant) and knowledge of your needs; **and**
- A clinical representative from your Intermediate Care Facility (ICF) if you get ICF care.

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

D. Your Care Manager

D1. What a Care Manager is

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

D2. Who gets a Care Manager

All Participants have a Care Manager. Your Care Manager assignment or selection first occurs when you enroll in PHP Care Complete FIDA-IDD Plan.

D3. How you can contact your Care Manager

When a Care Manager is assigned or selected, PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan.

D4. How you can change your Care Manager

You may change your Care Manager at any time, but you will have to choose from a list of PHP Care Complete FIDA-IDD Plan Care Managers. If the Care Manager's caseload permits, PHP Care Complete FIDA-IDD Plan must honor your request. To change Care Managers, contact Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

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

E1. Care from a Primary Care Provider (PCP)

You must choose a PCP to provide and manage your care. PHP Care Complete FIDA-IDD Plan will offer you the choice of at least three PCPs to select from. If you do not choose a PCP, one will be assigned to you. You can change your PCP at any time by contacting Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

Definition of a "PCP," and what a PCP does for you

Your PCP is your main doctor and will be responsible for providing many of your preventive and primary care services. Your PCP will be a part of your IDT. Your PCP will participate in developing your Life Plan, making coverage determinations as a participant of your IDT, and recommending or asking for many of the services and items your IDT or PHP Care Complete FIDA-IDD Plan will authorize.

Your choice of PCP

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

If you already have a PCP when you join the plan who does not already have an agreement with us to participate in our network, we will work with that PCP to help them join our network so you can continue to use them. However, if they refuse or are unable to join our network, you will still be able to continue using that PCP during the transition period (see page 51 more information).

When a clinic can be your PCP

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

Option to change your PCP

You may change your PCP for any reason, at any time. Simply call PHP Care Complete FIDA-IDD Plan and ask for a new PCP. The plan will process your request and tell you the effective date of the change, which will be within five business days of your request.

If your current PCP leaves our network or otherwise becomes unavailable, PHP Care Complete FIDA-IDD Plan will provide you with an opportunity to select a new PCP.

E2. Care from specialists and other network providers

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

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

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

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

E3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you *that your provider is leaving our plan so that you have* at least 15 days' notice so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified *in-network* provider to continue managing your health care needs.
- If you are currently undergoing medical treatment *or therapies with your current provider*, you have the right to ask for, and we will work with you to ensure, that the medically necessary treatment *or therapies* you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- *If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care* when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right

to make an appeal of our decision. *Refer to Chapter 9, Section D for information about making an appeal.*

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. *You may contact Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.*

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

If you need care that our plan covers and our network providers cannot give it to you, you can get permission from PHP Care Complete FIDA-IDD Plan 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. Please speak with your Care Manager if you need care from an out-of-network provider.

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

If you need an out-of-network provider, please work with PHP Care Complete FIDA-IDD Plan or your IDT to get approval to use an out-of-network provider and to find one that meets applicable Medicare or Medicaid requirements.

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

F. Getting approval for services and items that require PA

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

F1. Services you can get without first getting authorization

In most cases, you will need approval from PHP Care Complete FIDA-IDD Plan your IDT, or certain authorized providers before using other providers. This approval is called "PA." You can get services like the ones listed below without first getting approval:

- Emergency services from network providers or out-of-network providers.

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

  NOTE: Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Participant Services before you leave the service area. We can help you get dialysis while you are away.)
- Immunizations, including flu shots and COVID-19 vaccinations*, as well as hepatitis B vaccinations and pneumonia vaccinations, 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 *as long as you get them from a network provider].*
- PCP visits.
- Palliative care.
- Other preventive services.
- Services from public health agency facilities for tuberculosis screening, diagnosis and treatment, including Directly Observed Therapy (TB/DOT).
- Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
- Dental services through Article 28 clinics operated by Academic Dental Centers.
- Cardiac rehabilitation for the first course of treatment (a Physician or Registered Nurse (RN) authorization is required for courses of treatment following the first course).
- Supplemental education, wellness, and health management services.
- Additionally, if you are eligible to get services from Indian health providers, you may use these providers without approval from PHP Care Complete FIDA-IDD Plan or your IDT.

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

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

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

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

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

H. How to get behavioral health services

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 PHP Care Complete FIDA-IDD Plan, you will get a comprehensive assessment of your needs, including your need for behavioral health services. All of your needs, as identified in your assessment, will be addressed in your Life Plan. Your Life Plan will outline which behavioral health services you will get, from whom, and how often.

If you are getting services from a behavioral health provider at the time of your enrollment in PHP Care Complete FIDA-IDD Plan, 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 PHP Care Complete FIDA-IDD Plans' network.

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

I. How to get self-directed care

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

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

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

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

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

I2. Consumer Directed Personal Assistance Services (CDPAS)

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

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

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

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

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

J. How to get transportation services

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

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

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

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

K1. Care when you have a medical emergency

Definition of a medical emergency

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

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
    - there is not enough time to safely transfer you to another hospital before delivery.
    - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval from PHP Care Complete FIDA-IDD Plan or your IDT. You do not need to use a network provider. You may get emergency medical care whenever you need it,

anywhere in the U.S. or its territories from any provider with an appropriate state license.

- *As soon as possible, make sure that you tell our plan about your emergency.* We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Please call us at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week or contact your Care Manager. You can find this information on your Participant ID Card.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, PHP Care Complete FIDA-IDD Plan covers that. We also cover medical services during the emergency. To learn more, refer to the Covered Items and Services Chart in Chapter 4, Section D

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

After the emergency is over, you may need follow-up care to be sure you get better. Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency after all

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

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

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

K2. Urgently needed care

Definition of urgently needed care

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

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

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

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

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

For help finding urgent care facilities, please contact Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week, or contact your Care Manager. You can find this information on your Participant ID Card.

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

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

Our plan does not cover urgently needed care or any other non-emergency care that you get outside the United States.

K3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from PHP Care Complete FIDA-IDD Plan.

Please visit our website for information on how to obtain needed care during a declared disaster www.phpcares.org

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 Section A8 for more information.

L. What to do if you are billed directly for services and items covered by PHP Care Complete FIDA-IDD Plan

Providers should not bill you directly for covered services or items. Providers should only bill PHP Care Complete FIDA-IDD Plan for the cost of your covered services and items. If a provider sends you a bill instead of sending it to PHP Care Complete FIDA-IDD Plan you can send it to us to pay. **You should not pay the bill yourself. But if you do, it is your right to be paid back.**

If you have paid for your covered services or items, or if you have gotten a bill for covered services or items, refer to **Chapter 7, Sections A and B to learn what to do**.

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

PHP Care Complete FIDA-IDD Plan covers all services and items:

- that are medically necessary, **and**
- that are listed in the plan's Covered Items and Services Chart or that your IDT determines are necessary for you (refer to Chapter 4, Section D, **and**
- that you get by following plan rules.

If you get services or items that aren't covered by PHP Care Complete FIDA-IDD Plan, **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, Section E 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 a.m. to 8:00 p.m.

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

M1. Definition of a clinical research study

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

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

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

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from PHP Care Complete FIDA-IDD Plan, your IDT, or your PCP. The providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

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

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

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

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

If you are part of a study that Medicare has not approved, you will have to pay any costs for being in the study.

M3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). 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.

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

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

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

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- PHP Care Complete FIDA-IDD Plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from PHP Care Complete FIDA-IDD Plan or your IDT before you are admitted to the facility or your stay will not be covered

Medicare Inpatient Hospital coverage limits do not apply when you are a Participant in PHP Care Complete FIDA-IDD Plan. Durable medical equipment (DME)

O. Durable medical equipment (DME)

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

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items that PHP Care Complete FIDA-IDD Plan buys for you, such as prosthetics.

In this section, we discuss DME you must rent. As a Participant of PHP Care Complete FIDA-IDD Plan, you usually will not own the rented equipment, no matter how long we rent it for you. Examples of DME items we must rent for you are wheelchairs, hospital beds, and continuous positive airway pressure (CPAP) devices.

In certain situations, we will transfer ownership of the DME item to you. Call Participant Services to find out about the requirements you must meet and the papers you need to provide.

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

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

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

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined PHP Care Complete FIDA-IDD Plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you would have to make after your Medicaid ends**.

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

O3. Oxygen equipment benefits as a participant of our plan

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

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

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

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

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

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

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

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

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

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

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

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

P1. How you will get Medicare services

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

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

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or a Program of All- inclusive Care for the Elderly (PACE)	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from PHP Care Complete FIDA-IDD Plan when your new plan's coverage begins.

2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from PHP Care Complete FIDA-IDD Plan when your Original Medicare coverage begins.
3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from PHP Care Complete FIDA-IDD Plan when your Original Medicare coverage begins.

P2. How you will get Medicaid services

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

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

Chapter 4: Covered Items and Services

Introduction

This chapter tells you about the services PHP Care Complete FIDA-IDD Plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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A. Your covered items and services

This chapter tells you what items and services PHP Care Complete FIDA-IDD Plan pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5,. This chapter also explains limits on some services.

Because you are a FIDA-IDD Participant, you pay nothing for your covered items and services as long as you follow PHP Care Complete FIDA-IDD Plan's rules. Refer to Chapter 3, Section B 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 1*-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week*.

A1. During public health emergencies

PHP Care Complete FIDA-IDD Plan has adopted temporary policy changes and mandates in response to the public health emergency declaration (e.g., the COVID-19 pandemic) as defined in Federal and State specific directives, waivers, and amendments.

Managing your health, safety, and continued coverage of services during this emergency phase is our critical priority. PHP will relax rules to ensure that Participants can be effectively served in their homes, modify prior authorization and medical necessity rules for medical benefits as well as medication, payment rules to support health care providers affected by the public health emergency (PHE), and provide wider access to covered services delivered via Telehealth.

PHP Care Complete FIDA-IDD Plan's temporary coverage and flexibilities is allowable only until the end of the public health emergency (PHE) period, or thereafter as granted through Federal and State guidance.

If you need more information or help understanding what services are covered, call your Care Manager and/or Participant Services at 1*-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week*.

B. Rules against providers charging you for covered items or services

We do not allow PHP Care Complete FIDA-IDD plan providers to bill you for covered items or services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered items and services. If you do, refer to Chapter 7, Section *A,* or call Participant Services.

C. About our plan's Covered Items and Services Chart

The Covered Items and Services Chart in Section D tells you which items and services PHP Care Complete FIDA-IDD Plan pays for. It lists items and services in alphabetical order and explains the covered items and services.

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

- Your Medicare and Medicaid covered items and services must be provided according to the rules set by Medicare and Medicaid.
- The items and services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need items and services to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger your life, result in illness or infirmity, interfere with your capacity for normal activity, threaten some significant handicap or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- You get your care from a network provider. A network provider is a provider who works with PHP Care Complete FIDA-IDD Plan. In most cases, PHP Care Complete FIDA-IDD Plan will not pay for care you get from an out-of-network provider, unless it is approved by your Interdisciplinary Team (IDT) or PHP Care Complete FIDA-IDD Plan. Chapter 3, Section E has more information about using network and out-of-network providers.
- You have an IDT that will arrange and manage your care. For more information on your IDT, refer to Chapter 3, Section C.
- Most of the items and services listed in the Covered Items and Services Chart are covered only if your IDT, PHP Care Complete FIDA-IDD Plan or an authorized provider approves them. This is called prior authorization (PA). The Covered Items and Services Chart tells you when an item or service does not require PA.
- *All* preventive services are covered by PHP Care Complete FIDA-IDD Plan. You will find this apple 🍎 next to preventive services in the Covered Items and Services Chart.

D. The Covered Items and Services Chart

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Abdominal aortic aneurysm screening The plan will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
Adult day health care PHP Care Complete FIDA-IDD Plan will pay for adult day health care for Participants who are functionally impaired, not homebound, and who require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services. Adult day health care includes the following services: • medical • nursing • food and nutrition • social services • rehabilitation therapy • leisure time activities, which are a planned program of diverse meaningful activities • dental • pharmaceutical • other ancillary services	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
AIDS adult day health care PHP Care Complete FIDA-IDD Plan will pay for AIDS adult day health care programs for Participants with HIV. AIDS Adult Day Health Care programs include the following services: • individual and group counseling/education provided in a structured program setting • nursing care (including triage/assessment of new symptoms) • medication adherence support • nutritional services (including breakfast and/or lunch) • rehabilitative services • substance abuse services • mental health services • HIV risk reduction services	$0
Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified Primary Care Provider (PCP) or practitioner in a primary care setting. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, 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 PHP Care Complete FIDA-IDD Plan. In cases that are not emergencies, your IDT or PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan will pay for covered surgical procedures provided at ambulatory surgical centers.	$0
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. PHP Care Complete FIDA-IDD Plan will pay for this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Assertive community treatment (ACT) PHP Care Complete FIDA-IDD Plan 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
Bone mass measurement PHP Care Complete FIDA-IDD Plan 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. PHP Care Complete FIDA-IDD Plan will pay for the services once every 24 months, or more often if they are medically necessary. PHP Care Complete FIDA-IDD Plan will also pay for a doctor to look at and comment on the results. This service does not require PA.	$0
Breast cancer screening (mammograms) PHP Care Complete FIDA-IDD Plan will pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and older • clinical breast exams once every 24 months This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Cardiac (heart) rehabilitation services PHP Care Complete FIDA-IDD Plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Participants must meet certain conditions with a provider's order. PHP Care Complete FIDA-IDD Plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. This service does not require PA.	$0
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) PHP Care Complete FIDA-IDD Plan pays for one visit a year with your PCP to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, **or** • give you tips to make sure you are eating well. This service does not require PA.	$0
Cardiovascular (heart) disease screening and testing PHP Care Complete FIDA-IDD Plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Care management Care management is individually designed to help the Participant get access to needed services. Care management helps to assure the Participant's health and welfare and increase the Participant's independence and quality of life. Refer to Chapter 3, Section D for more information about care management.	$0
Cervical and vaginal cancer screening PHP Care Complete FIDA-IDD Plan will pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months This service does not require PA.	$0
Chemotherapy PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan will pay for the following services: • adjustments of the spine to correct alignment	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Colorectal cancer screening PHP Care Complete FIDA-IDD Plan will pay for the following: • Barium enema » Covered once every 48 months if you're 45 or over and do not meet high risk criteria, when the test is used instead of a flexible sigmoidoscopy » Covered once every 24 months if you're at high risk for colorectal cancer, when this test is used instead of a colonoscopy. • Colonoscopy » Covered once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy. • Multitarget stool DNA » Covered once every 3 years if you're 45 to 85 years of age and do not meet high risk criteria. • Blood-based Biomarker Tests ○ Covered once every 3 years if you're 45 to 85 years of age and do not meet high risk criteria • Fecal occult blood test » Covered once every 12 months if you're 45 or older. • Guaiac-based fecal occult blood test or fecal immunochemical test » Covered once every 12 months if you're 50 or older. *This benefit is continued on the next page*	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Colorectal cancer screening (continued) • Flexible sigmoidoscopy » Covered once every 48 months for most people 45 or older if you are at high risk for colorectal cancer from the last flexible sigmoidoscopy or barium enema. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy. As of January 1, 2023, colorectal cancer screening tests include a follow-up screening colonoscopy after a covered non-invasive stool-based colorectal cancer screening test returns a positive result. This service does not require PA.	
Consumer directed personal assistance services (CDPAS) PHP Care Complete FIDA-IDD Plan will pay for CDPAS, which provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Participants who choose CDPAS have flexibility and freedom to choose their caregivers. The Participant or the person acting on the Participant's behalf is responsible for recruiting, hiring, training, supervising, and, if necessary, terminating caregivers providing CDPAS services.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for		What you must pay
	Continuing day treatment PHP Care Complete FIDA-IDD Plan will pay for continuing day treatment. This service helps Participants maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Services include: • assessment and treatment planning • discharge planning • medication therapy • medication education • case management • health screening and referral • rehabilitative readiness development • psychiatric rehabilitative readiness determination and referral • symptom management	$0
	Day treatment - Office for People With Developmental Disabilities (OPWDD) PHP Care Complete FIDA-IDD Plan will pay for OPWDD day treatment. Day treatment is a combination of diagnostic and treatment services provided to individuals with intellectual and developmental disabilities in need of a broad range of clinically supported and structured habilitation services.	$0

	Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
	Defibrillator (implantable automatic) PHP Care Complete FIDA-IDD Plan 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

Services that PHP Care Complete FIDA-IDD Plan pays for		What you must pay
	Dental services PHP Care Complete FIDA-IDD Plan will pay for the following dental services: • oral exams once every six months • cleaning once every six months • dental x-rays once every six months • diagnostic services • restorative services • endodontics, periodontics, and extractions • dental prosthetics and orthotic appliances required to alleviate a serious condition, including one that affects a Participant's employability • other oral surgery • dental emergencies • other necessary dental care X-rays and other dental services must be authorized by your dentist. However, dental services provided through Article 28 Clinics operated by Academic Dental Centers do not require PA. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Depression screening PHP Care Complete FIDA-IDD Plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and recommendations for additional treatments. This service does not require PA.	$0
Diabetes screening PHP Care Complete FIDA-IDD Plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Diabetic self-management training, services, and supplies PHP Care Complete FIDA-IDD Plan 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, PHP Care Complete FIDA-IDD Plan 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) PHP Care Complete FIDA-IDD Plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. • PHP Care Complete FIDA-IDD Plan will pay for training to help you manage your diabetes, in some cases.	$0
Diagnostic testing Refer to “Outpatient diagnostic tests and therapeutic services and supplies” in this chart.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Directly Observed Therapy for Tuberculosis (TB/DOT) TB/DOT is the direct observation of oral ingestion of TB medications to assure patient compliance with the physician's prescribed medication regimen.	$0
Durable medical equipment (DME) and related supplies DME includes items such as: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps • speech generating devices • oxygen equipment and supplies • nebulizers • walkers Other items may be covered. *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.* ***This benefit is continued on the next page***	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Durable medical equipment (DME) and related supplies (continued) *Generally, PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan authorizes a doctor or other provider's request for the brand. However, if you are new to PHP Care Complete FIDA-IDD Plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, 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 PHP Care Complete FIDA-IDD Plan coverage decision, you or your provider may file an appeal. You can also file an appeal if you do not agree with your provider's decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9, Sections C and D.*	

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical or behavioral health emergency. A medical or behavioral health emergency is a condition with severe symptoms, severe pain, or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or to that of your unborn child; **or** • serious impairment to bodily functions; **or** • serious dysfunction of any bodily organ or part; **or** • serious disfigurement of such person; **or** • in the case of a pregnant woman in active labor, when: » there is not enough time to safely transfer you to another hospital before delivery. » a transfer to another hospital may pose a threat to your health or safety or that of your unborn child. This coverage is within the U.S. and its territories. This service does not require PA.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, your Care Manager will assist you to 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 PHP Care Complete FIDA-IDD Plan approves your stay.*

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. PHP Care Complete FIDA-IDD Plan will pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (birth control pills, patch, ring, IUD, injections, implants) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap, emergency contraception, pregnancy tests) • counseling and diagnosis of infertility, and related services • counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions, as part of a family planning visit • treatment for sexually transmitted infections (STIs) • voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • abortion These services do not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Gym Membership/ Physical Fitness Members that attend gym or class (online or in person) a minimum of 26 times in a 6-month period will be reimbursed up to $200 every six months (up to $400 annually) upon receipt of payment and confirmation of attendance.	$0
Health and wellness education programs PHP Care Complete FIDA-IDD Plan will pay for health and wellness education for Participants and their caregivers, which includes: • classes, support groups, and workshops • educational materials and resources • website, email, or mobile application communications These services are provided on topics including, but not limited to: heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Hearing services PHP Care Complete FIDA-IDD Plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include: • hearing aid selecting, fitting, and dispensing • hearing aid checks following dispensing • conformity evaluations and hearing aid repairs • audiology services, including examinations and testing • hearing aid evaluations and hearing aid prescriptions • hearing aid products, including hearing aids, earmolds, special fittings, and replacement parts when authorized by an audiologist	$0
HIV screening PHP Care Complete FIDA-IDD Plan 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, PHP Care Complete FIDA-IDD Plan pays for up to three HIV screening tests during a pregnancy. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Home-delivered and congregate meals/Meal benefit This service allows up to two meals per day for Participants who cannot prepare or access nutritionally adequate meals for themselves.	$0
Home health services Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency. PHP Care Complete FIDA-IDD Plan 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

	Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
	Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your Life Plan; • Participant training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	*$0*
	Home visits by medical personnel PHP Care Complete FIDA-IDD Plan 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

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • drugs to treat symptoms and pain • short-term respite care • home care **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • Refer to Section F of this chapter for more information. **For services covered by PHP Care Complete FIDA-IDD Plan but not covered by Medicare Part A or B:** • PHP Care Complete FIDA-IDD Plan 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 nothing for these services. **This benefit is continued on the next page**	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Hospice care (continued) **For drugs that may be covered by** PHP Care Complete FIDA-IDD Plan'**s Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. **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. Please call PHP Care Complete FIDA-IDD Plan at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.	
Immunizations PHP Care Complete FIDA-IDD Plan will pay for the following services: • pneumonia vaccine • flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • other vaccines if you are at risk and they meet Medicare Part B coverage rules PHP Care Complete FIDA-IDD Plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, to learn more. These services do not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Inpatient acute hospital care, including substance abuse and rehabilitative services PHP Care Complete FIDA-IDD Plan will pay for the following services, and maybe other services not listed here: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • blood, including storage and administration • physician services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	$0 You must get approval from PHP Care Complete FIDA-IDD Plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

	Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
	Inpatient acute hospital care, including substance abuse and rehabilitative services (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. *Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If PHP Care Complete FIDA-IDD Plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.*	
	Inpatient services in a psychiatric hospital PHP Care Complete FIDA-IDD Plan will pay for mental health care services that require a hospital stay, including days in excess of the Medicare 190-day lifetime maximum.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If your inpatient stay is not reasonable and necessary, PHP Care Complete FIDA-IDD Plan will not pay for it. However, in some cases PHP Care Complete FIDA-IDD Plan will pay for services you get while you are in the hospital or a SNF. PHP Care Complete FIDA-IDD Plan 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

Services that PHP Care Complete FIDA-IDD Plan pays for		What you must pay
	Intensive psychiatric rehabilitation treatment (IPRT) programs PHP Care Complete FIDA-IDD Plans will Plan will pay for time limited, active psychiatric rehabilitation designed to: • help a Participant form and achieve mutually agreed upon goals in living, learning, working, and social environments • intervene with psychiatric rehabilitative technologies to help a Participant overcome functional disabilities	$0
	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) PHP Care Complete FIDA-IDD Plan will pay for a facility that provides comprehensive and individualized health care and rehabilitation services to a Participant to promote their functional status and independence.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Kidney disease services and supplies, including End-Stage Renal Disease (ESRD) services PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan must authorize it. » PHP Care Complete FIDA-IDD Plan 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, Section E, or when your provider for this service is temporarily unavailable or inaccessible • inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • home dialysis equipment and supplies • certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart. Kidney disease education services do not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
Medical nutrition therapy This benefit is for Participants with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when *referred* by your provider. PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan, 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 PHP Care Complete FIDA-IDD Plan. A provider must prescribe these services and renew the request to the IDT or to PHP Care Complete FIDA-IDD Plan each year if your treatment is needed in the next calendar year. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Medical social services PHP Care Complete FIDA-IDD Plan 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 Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. PHP Care Complete FIDA-IDD Plan will pay for the following drugs: • drugs you don't usually give yourself and are injected or infused while you are getting provider, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using DME (such as nebulizers) that were authorized by your IDT or PHP Care Complete FIDA-IDD Plan • clotting factors you give yourself by injection if you have hemophilia • immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a provider certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • antigens • certain oral anti-cancer drugs and anti-nausea drugs • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases *This benefit is continued on the next page*	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Medicare Part B prescription drugs (continued) We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 provides additional information about your outpatient prescription drug coverage.	
Medication therapy management (MTM) services PHP Care Complete FIDA-IDD Plan 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 *provides additional information about MTM programs.*	$0
Mobile mental health treatment PHP Care Complete FIDA-IDD Plan 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

Services that PHP Care Complete FIDA-IDD Plan pays for		What you must pay
	Moving assistance PHP Care Complete FIDA-IDD Plan will pay for a Participant who is transitioning from an institutional setting to a community-based setting. This service covers the cost of physically moving the Participant's furnishings and other belongings to the community-based setting where s/he will reside. Plan must use a moving company licensed/certified by the New York State Department of Transportation.	$0
	Nurse advice call line PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan.	$0
	Nursing facility care PHP Care Complete FIDA-IDD Plan will pay for nursing facilities for Participants who need 24-hour nursing care and supervision outside of a hospital.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Nutrition (includes nutritional counseling and educational services) PHP Care Complete FIDA-IDD Plan will pay for nutrition services provided by a qualified nutritionist. Services include: • assessment of nutritional needs and food patterns • planning for providing food and drink appropriate for the individual's physical and medical needs and environmental conditions These services do not require PA.	$0
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, PHP Care Complete FIDA-IDD Plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your Care Manager or PCP to find out more. This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	*$0*
OPWDD certified outpatient clinic PHP Care Complete FIDA-IDD Plan will pay for clinical services provided at an Article 16 clinic. Clinical services include: • Rehabilitation/habilitation services (e.g., physical therapy, occupational therapy, psychology, speech and language pathology, social work); • Medical/dental services; **and** • Health care services (e.g., nursing, dietetics and nutrition, audiology, podiatry).	$0

Services that PHP Care Complete FIDA-IDD Plan pays for		What you must pay
	Other supportive services the IDT determines are necessary PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD plan 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

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Outpatient diagnostic tests and therapeutic services and supplies PHP Care Complete FIDA-IDD Plan will pay for the following services, and maybe other services not listed here: • CT scans, MRIs, EKGs and X-rays when a provider orders them as part of treatment for a medical problem • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition • blood, including storage and administration • other outpatient diagnostic tests	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Outpatient hospital services PHP Care Complete FIDA-IDD Plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. PHP Care Complete FIDA-IDD Plan will pay for the following services, and maybe other services not listed here: • services in an emergency department or outpatient clinic, such as outpatient surgery or observation services » Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." » Sometimes you can be in the hospital overnight and still be an "outpatient." » You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101. • 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

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Outpatient mental health care PHP Care Complete FIDA-IDD Plan will pay for mental health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP), • a physician assistant (PA), **or** • any other Medicare-qualified mental health care professional as allowed under applicable state laws. PHP Care Complete FIDA-IDD Plan will pay for the following services: • individual therapy sessions • group therapy sessions • clinic services • day treatment • psychosocial rehab services [Participants may directly access one assessment from a network provider in a twelve (12)-month period without getting PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Outpatient rehabilitation services PHP Care Complete FIDA-IDD Plan will pay for Physical Therapy (PT), Occupational Therapy (OT), and Speech Language Therapy (SLT). You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0
Outpatient surgery PHP Care Complete FIDA-IDD Plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0
Over-the-Counter (OTC) Flex Card • Up to $150 per month debit card for Over the Counter items. • Includes out-of-pocket expenses on approved health products, healthy grocery items, fresh produce, and healthy prepared meals. Items can be obtained from participating retail locations, or you may get home delivery options when you order online, by phone, or by mail. Amount if unused, does not carry over to the following month. Please call Participant Services or visit www.phpcares.org to learn more about your flex card benefit.	$0

	Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
	Palliative care PHP Care Complete FIDA-IDD Plan will pay for interdisciplinary end-of-life care and consultation with the Participant and his/her family members. These services help to prevent or relieve pain and suffering and to enhance the Participant's quality of life. Services include: • family palliative care education • pain and symptom management • bereavement services • massage therapy • expressive therapies These services do not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Partial hospitalization Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center. Partial hospitalization is more intense than the care in a provider or therapist's office and is an alternative to inpatient hospitalization. PHP Care Complete FIDA-IDD Plan 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	$0
Personal care services PHP Care Complete FIDA-IDD Plan will pay for personal care services to assist Participants with activities such as personal hygiene, dressing, feeding, and nutritional and environmental support function tasks (meal preparation and housekeeping). PCS must be medically necessary, ordered by the Participant's physician, and provided by a qualified person according to a plan of care.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Personal emergency response services (PERS) PHP Care Complete FIDA-IDD Plan 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) PHP Care Complete FIDA-IDD Plan 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) PHP Care Complete FIDA-IDD Plan will pay for certain generic, brand, and non-prescription drugs to treat a Participant's illness or condition. Chapters 5 and 6 *provide* additional information about your pharmacy benefits.	$0

	Physician/Provider services, including Primary Care Provider (PCP) office visits
	
	PHP Care Complete FIDA-IDD Plan will pay for the following services:
	• medically necessary health care or surgery services given in places such as:
	  ○ physician's office
	  ○ certified ambulatory surgical center
	  ○ hospital outpatient department
	• consultation, diagnosis, and treatment by a specialist
	• basic hearing and balance exams given by your PCP or a specialist, if your doctor orders them to find out whether you need treatment
	• *certain telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner, for patients in rural areas or other places approved by Medicare*
	  ○ *You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth either via phone, and audio/video chat*
	• *some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for Participants in certain rural areas or other places approved by Medicare*
	• *telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the Participant's home*
	• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke
		$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
This benefit is continued on the next page	
Physician/Provider services, including Primary Care Provider (PCP) office visits (continued) • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the Participant's home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for Participants with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o you have an in-person visit within 6 months prior to your first telehealth visit o you have an in-person visit every 12 months while receiving these telehealth services o exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o you're not a new patient **and** o the check-in isn't related to an office visit in the past 7 days **and** o the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment **This benefit is continued on the next page**	

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay

Physician/Provider services, including Primary Care Provider (PCP) office visits (continued)
• evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:
  ○ you're not a new patient **and**
  ○ the evaluation isn't related to an office visit in the past 7 days **and**
  ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
• second opinion *by another network provider* before surgery
Participants may use PCPs without first getting PA.	

Podiatry services PHP Care Complete FIDA-IDD Plan will pay for the following services: • care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for Participants with conditions affecting the legs, such as diabetes	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Preventive services PHP Care Complete FIDA-IDD Plan will pay for all preventive tests and screenings covered by Medicare and Medicaid to help prevent, find, or manage a medical problem. This includes, but is not limited to, all the preventive services listed in this chart. You will find this apple next to preventive services in this chart.	$0
Private duty nursing services PHP Care Complete FIDA-IDD Plan 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
Prostate cancer screening exams For men age 50 and older, PHP Care Complete FIDA-IDD Plan will pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test This service does not require PA.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.	$0
Pulmonary rehabilitation services PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan for pulmonary rehabilitation from the provider treating the COPD.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Respiratory care services PHP Care Complete FIDA-IDD Plan 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
Sexually transmitted infections (STIs) screening and counseling PHP Care Complete FIDA-IDD Plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A PCP or other primary care practitioner must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. PHP Care Complete FIDA-IDD Plan 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. PHP Care Complete FIDA-IDD Plan will pay for these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor's office. This service does not require PA.	$0

	Skilled nursing facility (SNF) care PHP Care Complete FIDA-IDD Plan covers an unlimited number of days of SNF care and there is no prior hospital stay required. PHP Care Complete FIDA-IDD Plan will pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept PHP Care Complete FIDA-IDD Plan 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)	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
• a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	
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: • PHP Care Complete FIDA-IDD Plan 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. PHP Care Complete FIDA-IDD Plan will pay for smoking cessation counseling for pregnant women and women up to six months after birth. This smoking cessation counseling is in addition to benefits for prescriptions and over-the-counter smoking cessation products. This service does not require PA.	$0
Substance abuse services: Opioid treatment services PHP Care Complete FIDA-IDD Plan will pay for opioid treatment services to help Participants manage addiction to opiates such as heroin. Opioid treatment programs administer medication, generally methadone by prescription, along with a variety of other clinical services. These programs help Participants control the physical problems associated with opiate dependence and provide the opportunity for Participants to make major lifestyle changes over time.	$0

	Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
	Substance abuse services: Outpatient medically supervised withdrawal PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan will pay for outpatient substance abuse services including individual and group visits. Participants may directly access one assessment from a network provider in a twelve (12)-month period without getting PA.	$0
	Substance abuse services: Substance abuse program PHP Care Complete FIDA-IDD Plan 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

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Supervised exercise therapy (SET) The plan will pay for SET for Participants with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in Participants with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Telehealth services PHP Care Complete FIDA-IDD Plan will pay for telehealth services for Participants with conditions that require frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services to reduce the need for in-office visits. Participants eligible for this service include those with the following conditions: congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition, or enteral feeding. These services do not require PA.	$0
Transitional services These services assist a Participant who is transitioning from an institutional setting to a home in the community where s/he will reside. These services cover expenses related to setting up a household such as: • payment of the first and last month's rent; • utility and rental deposits; • purchase of basic essential household items such as furniture, linens, and kitchen supplies; **and** • health and safety assurances such as pest removal, allergen control, or one-time cleaning prior to occupancy. These services are limited to a Participant transitioning from a nursing facility, Institution for Mental Disease (IMD) or ICF/IID to her/his home or the home of a family member where s/he will live.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Transportation services (emergency and non-emergency) PHP Care Complete FIDA-IDD Plan will pay for emergency and non-emergency transportation. Transportation is provided for medical appointments and services. Transportation is also available for non-medical events or services, such as religious services, community activities, or supermarkets, through transportation modes including but not limited to: • taxi • bus • subway • van • medical transport • ambulance • fixed wing or airplane transport • invalid coach • delivery • other means	$0

	Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). Urgent care does not include primary care services or services provided to treat an emergency medical condition. This coverage is within the U.S. and its territories. These services do not require PA.	$0
	Utility Benefit $600 annual allowance available through your Over-the-Counter (OTC) Flex Card to help pay for home utilities such as gas, electric, water, and internet services.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Vision care: Eye and vision exams and eye care The plan will pay for outpatient doctor services for the diagnosis and treatment of visual defects, eye disease, and eye injury. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. Examinations for refraction are limited to every two (2) years unless medically necessary. For people at high risk of glaucoma, PHP Care Complete FIDA-IDD Plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes, • African-Americans who are age 50 and older, **and** • Hispanic Americans who are 65 or older. Article 28 Clinic services may be directly accessed without PA from PHP Care Complete FIDA-IDD Plan or your IDT.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
Vision Care: Eyeglasses (lenses and frames) and contact lenses PHP Care Complete FIDA-IDD Plan 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. .PHP Care Complete FIDA-IDD Plan 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.) PHP Care Complete FIDA-IDD Plan will also pay for corrective lenses, frames, and replacements if you need them after a cataract removal without a lens implant. Article 28 Clinic services may be directly accessed without PA from PHP Care Complete FIDA-IDD Plan or your IDT.	$0

Services that PHP Care Complete FIDA-IDD Plan pays for	What you must pay
"Welcome to Medicare" Preventive Visit PHP Care Complete FIDA-IDD Plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0
Wellness counseling PHP Care Complete FIDA-IDD Plan will pay for wellness counseling to help medically stable Participants maintain their optimal health status. A Registered Professional Nurse (RN) works with the Participant to reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. The RN is also able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma, or high cholesterol. The RN can help the Participant to identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder. These services do not require PA.	$0

E. Home and Community-Based Waiver Services Chart

	Home and Community-Based Waiver Services that PHP Care Complete FIDA-IDD Plan pays for **Some services may have limitations. Contact your Care Manager for more information.**	What you must pay
	Assistive Technology-Adaptive Devices Includes items, equipment, or product system that is modified or customized to be used to increase, maintain, or improve functional capabilities.	$0
	Community Habilitation This service is directed toward service delivery in community (non-certified) settings to promote independence and community integration.	$0

Home and Community-Based Waiver Services that PHP Care Complete FIDA-IDD Plan pays for **Some services may have limitations. Contact your Care Manager for more information.**		What you must pay
	Community Transition Services (CTS) These services help a Participant transition from living in an institution to living in the community. CTS includes: • the cost of moving furniture and other belongings • buying certain essential items such as linen and dishes • security deposits, including broker's fees required to obtain a lease on an apartment or home • buying essential furnishings • set-up fees or deposits for utility or service access (for example, telephone, electricity, or heating) • health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy CTS cannot be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.	$0
	Day Habilitation This service helps the Participant to achieve maximum functional level. The service is coordinated with any physical, occupational or speech therapies. The service may serve to reinforce skills, behaviors, or lessons taught in other settings.	$0

Home and Community-Based Waiver Services that PHP Care Complete FIDA-IDD Plan pays for **Some services may have limitations. Contact your Care Manager for more information.**		What you must pay
	Environmental Modifications PHP Care Complete FIDA-IDD Plan will pay for modifications to the home that are necessary to ensure the health, welfare, and safety of the Participant. Environmental modifications may include: • installation of ramps and grab bars • widening of doorways • modifications of bathroom facilities • installation of specialized electrical or plumbing systems to accommodate necessary medical equipment • any other modification necessary to ensure the Participant's health, welfare or safety	$0
	Fiscal Intermediary (FI) This service is for Participants who are self-directing. The FI supports the Participant with billing and payment of goods and services and general administrative supports.	$0
	Individual Directed Goods and Services (IDGS) IDGS are services, equipment, or supplies that are not provided through Medicaid. The service supports the Participant's independence.	$0
	Intensive Behavioral Services (IBS) IBS is a short-term service focused on developing behavioral management strategies to ensure health and safety and improve the Participant's quality of life.	$0

	Home and Community-Based Waiver Services that PHP Care Complete FIDA-IDD Plan pays for **Some services may have limitations. Contact your Care Manager for more information.**	What you must pay
	Live-in Caregiver The live-in caregiver resides in the Participant's home and provides supports to address physical, social, and emotional needs in order for the Participant to live safely and successfully in their own home. The live-in caregiver cannot be related to the Participant by blood or marriage.	$0
	Pathway to Employment This service provides career planning and support services. Assistance is provided for the Participant to obtain, maintain, or advance in competitive employment or self-employment.	$0
	Prevocational Services This service provides learning and work experience, including volunteering. The Participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment.	$0
	Residential Habilitation This service includes activities or supports that are designed to help the Participant pursue or maintain outcomes in the Participant's life that have value to the Participant.	$0

Home and Community-Based Waiver Services that PHP Care Complete FIDA-IDD Plan pays for **Some services may have limitations. Contact your Care Manager for more information.**		What you must pay
	Respite Respite care provides relief to non-paid caregivers who provide primary care and support to the Participant. The location for this service is the Participant's home, but respite services may also be provided in another community dwelling or facility acceptable to the Participant.	$0
	Supported Employment (SEMP) SEMP services provide intensive ongoing support for a Participant to obtain and maintain a job in the general workforce and to be compensated at or above the minimum wage.	$0
	Support Brokerage This service is provided to Participants who are self-directing. The Support Broker provides assistance and skills training in the area of understanding and managing responsibilities for self-direction, community inclusion, and independent living.	$0
	Vehicle Modifications This service includes physical changes to a Participant's vehicle, required by the Participant's Life Plan, that are necessary to ensure the health, welfare and safety of the Participant or that enable the Participant to function with greater independence.	$0

F. Benefits covered outside of PHP Care Complete FIDA-IDD Plan

The following services are not covered by PHP Care Complete FIDA-IDD Plan but are available through Medicare or Medicaid. Your IDT will help you access these services.

F1. Freestanding birth center services

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

F2. Hospice services

Hospice services provided to Participants by Medicare approved hospice providers are paid directly by Medicare. Hospice is a coordinated program of home and inpatient care that provides non-curative medical and support services. A Participant has the right to elect hospice if his/her provider and hospice medical director determine that the Participant has a terminal prognosis. This means that the Participant has a terminal illness and is expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Hospice programs provide Participants and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

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

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

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

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

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

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

For drugs that may be covered by PHP Care Complete FIDA-IDD Plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5.

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. If you have questions, please call PHP Care Complete FIDA-IDD Plan at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

G. Benefits not covered by PHP Care Complete FIDA-IDD Plan, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by PHP Care Complete FIDA-IDD Plan. Excluded means that PHP Care Complete FIDA-IDD Plan 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 PHP Care Complete FIDA-IDD Plan under any conditions and some that are excluded by PHP Care Complete FIDA-IDD Plan only in some cases.

PHP Care Complete FIDA-IDD Plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Participant Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9.

In addition to any exclusions or limitations described in the Covered Items and Services Chart, **the following items and services are not covered by PHP Care Complete FIDA-IDD Plan**:

- 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 PHP Care Complete FIDA-IDD Plan, Refer to Chapter 3 *for* more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, PHP Care Complete FIDA-IDD Plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under PHP Care Complete FIDA-IDD Plan, we will reimburse the veteran for the difference. Participants are still responsible for their cost sharing amounts.

Chapter 5: Getting your outpatient prescription drugs and other covered medications through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs and other covered medications. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook.*

PHP Care Complete FIDA-IDD Plan also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Covered Items and Services Chart in Chapter 4, Section D.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

- You must have a doctor or other provider write your prescription, which must be valid under applicable state law. A written prescription is required for both prescription and over-the-counter (OTC) drugs.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription unless PHP Care Complete FIDA-IDD Plan or your Interdisciplinary Team (IDT) has authorized you to use an out-of-network pharmacy.
- Your prescribed drug must be on the plan's *List of Covered Drugs* (Drug List).
    - If it is not on the Drug List, we may be able to cover it by giving you an exception.
    - Refer to Chapter 9, Section F3 to learn about asking for an exception.

- Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Medically accepted indications include both the uses approved by the Food and Drug Administration (FDA) and off-label uses supported by one or more of three compendia specified in section 1927(g)(I)(B)(i) of the Social Security Act.

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions **only** if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan Participants. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

A2. Using your Participant ID Card when you fill a prescription

To fill your prescription, **show your Participant ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription or OTC drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to lookup your plan enrollment information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask PHP Care Complete FIDA-IDD Plan to pay you back. If you cannot pay for the drug, contact Participant Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, refer to Chapter 7, Section B.
- If you need help getting a prescription filled, you can contact Participant Services *or your Care Manager*.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, you can contact Participant Services or your Care Manager.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility or intermediate care facility (ICF).
    - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact your Care Manager or Participant Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

A6. Using mail-order services to get your drugs

Can you use mail order services to get your drugs?

Yes, for certain drugs, you can use the plan's network mail order services.

Generally, the drugs available through mail order are drugs that you take on a regular basis for a chronic or long-term medical condition. Please use our Drug List to identify which drugs are available through mail order.

Our plan's mail order service allows you to order a 60 to 90-day supply through Birdi, Inc., formerly known as MedImpact Direct.

How do I fill my prescriptions by mail?

To get information about filling your prescriptions by mail, please call Birdi at 1-855-873-8739. TTY users should call 711. You may also mail prescriptions to the below address.

Birdi
P.O. Box 51580
Phoenix, AZ 85076-1580

Usually, a mail order prescription will get to you within 10 business days. If your mail order prescription is delayed, please call Birdi at 1-855-873-8739 and 711 for TTY users.

How will the mail order service process my prescription?

The mail order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail order prescriptions:

1. **New prescriptions the pharmacy gets from you**
   The pharmacy will automatically fill and deliver new prescriptions it gets from you. You can submit a registration form online at www.medimpact.com, by mail to the address on your registration form, or by phone at 1-855-873-8739 and 711 for TTY users.
2. **New prescriptions the pharmacy gets directly from your provider's office**
   Your prescriptions will be filled once the pharmacy has received the request from your provider.
3. **Refills on mail order prescriptions**
   For refills of your drugs, please call Birdi at 1-855-873-8739 and 711 for TTY users, three weeks before your next refill date. If you have run out of refills on your current prescription, you will also need to obtain a new prescription.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Participant Services or your Care Manager for more information.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. *We have network pharmacies outside of our service area where you can get your prescriptions filled as a Participant of our plan.*

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- *During a declared disaster.*
- *You are outside of the service area and you are not near a pharmacy in our nationwide network and you need a refill.*

In these cases, please check first with Participant Services to find out if there is a network pharmacy nearby.

A9. Paying you back if you pay for a prescription

Sometimes a pharmacy that is not in the plan's network will require you to pay the full cost for the drug and seek payment from us. You can ask PHP Care Complete FIDA-IDD Plan to pay you back.

To learn more about this, refer to Chapter 7, Section B.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and some prescription and OTC drugs and items covered under your Medicaid benefits.

The Drug List includes both brand-name and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Generally, generics work just as well as brand name drugs and usually cost less. There are generic drug substitutes available for many brand name drugs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Participant Services or your Care Manager.

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.phpcares.org.. The Drug List on the website is always the most current one.
- Call Participant Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

B3. Drugs that are not on the Drug List

The plan does not cover all prescription drugs or all OTC drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

PHP Care Complete FIDA-IDD Plan will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9, Section D2.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by PHP Care Complete FIDA-IDD Plan for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- drugs used to promote fertility
- drugs used for cosmetic purposes or to promote hair growth
- drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- drugs used for treatment of anorexia, weight loss, or weight gain
- outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of three tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs).

	A network pharmacy A one-month or up to a 30-day supply	**The plan's mail order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 31-day supply
Tier 1 (Generic Drugs)	*$0*	*$0*	*$0*
Tier 2 (*Brand Drugs*)	*$0*	*$0*	*$0*
Tier 3 (Non-Medicare Covered Drugs and Non-Medicare OTC Drugs, both Generic and Brand)	*$0*	*$0*	*$0*

To find out which tier your drug is in, look for the drug in the plan's Drug List.

C. Limits on some drugs

For certain prescription and covered OTC drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that the prescribing provider will have to give us or your IDT extra information, or you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks the rule should not apply to your situation, you should ask PHP Care Complete FIDA-IDD Plan or your IDT to make an exception. PHP Care Complete FIDA-IDD Plan or your IDT may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9, section F3.

1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. *If* there is a generic version of a brand name drug, our network pharmacies will give you the generic version.

- We usually will not pay for the brand name drug when there is a generic version.
- However, if your provider has told us the medical reason that the generic drug will not work for you ***or*** has written "No substitutions" on your prescription for a brand name drug ***or*** has told us the medical reason that neither the genetic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. Getting plan or IDT approval in advance

For some drugs, you or your doctor must get approval from the plan or your IDT before you fill your prescription. If you don't get approval, we may not cover the drug. Your IDT may approve drugs as part of your Life Plan or you can ask PHP Care Complete FIDA-IDD Plan for approval.

During the first 90 days of your participation in the plan, you do not need the plan or your IDT to approve when you ask for a refill for an existing prescription, even if the drug is not on our Drug List or is limited in some way. Refer to page 151 for more information about getting a temporary supply.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, PHP Care Complete FIDA-IDD Plan's rules may require you to try Drug A first.

If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Participant Services or check our website at www.phpcares.org.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section C above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask PHP Care Complete FIDA-IDD Plan or your IDT for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask PHP Care Complete FIDA-IDD Plan or your IDT to approve the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:
   - is no longer on the plan's Drug List, **or**
   - was never on the plan's Drug List, **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in the plan last year.
     - *We will cover a temporary supply (or supplies) of your drug **during the first 90 days of the calendar year**.*
     - *This temporary supply (or supplies) will be for up to 30* days.

- *If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30* days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You are new to the plan.
  - We will cover a temporary supply of your drug during the first 90 days of your participation in the plan.
  - This temporary supply will be for up to 30 days.
  - If *your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30* days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
  - We will cover a transition supply of prescribed drugs when you have to change your level of care
  - To ask for a temporary supply of a drug, call Participant Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Participant Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- You can ask for an exception.

You and your provider can ask PHP Care Complete FIDA-IDD Plan or your IDT to make an exception. For example, you can ask PHP Care Complete FIDA-IDD Plan or your IDT to approve a drug even though it is not on the Drug List. Or you can ask PHP Care Complete FIDA-IDD Plan or your IDT to approve and cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us or your IDT to make an exception and cover the drug in the way you would like it to be covered for next year.
- PHP Care Complete FIDA-IDD Plan or your IDT will answer when you ask for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9, section F3.

If you need help asking for an exception, you can contact Participant Services *or your Care Manager*.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but PHP Care Complete FIDA-IDD Plan may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval (PA) for a drug. (PA is permission from PHP Care Complete FIDA-IDD Plan before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**

- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check PHP Care Complete FIDA-IDD Plan's up to date Drug List online at www.phpcares.org **or**
- Call PHP Care Complete FIDA-IDD Plan to check the current Drug List at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

Some changes to the Drug List will happen **immediately**. For example:

- ***A new generic drug becomes available.*** *Sometimes, a new* generic *drug comes* on the market *that works as well as a* brand name *drug on the Drug List now. When that happens, we may remove the* brand name *drug* and add the new generic drug*, but your cost for the new drug will stay the same.*

  When we add the new generic drug, we may also decide to keep the brand name *drug on the list but change its coverage rules or limits.*

  - *We may not tell you before we make this change, but we will send you information about the specific change* we made once it happens*.*
  - *You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.*

- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. If a drug you are taking is unsafe, please contact the prescribing provider to choose an alternative medication.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- *We add a generic drug that is not new to the market* ***and***
  - *Replace a brand name drug currently on the Drug List* ***or***
  - *Change the coverage rules or limits for the brand name drug.*

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide;

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9, Section F3.

We may make changes to the drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing facility or an ICF, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact your Care Manager or Participant Services.

F2. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the

notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4, Section F2.

G. Programs on drug safety and managing drugs

G1. Programs to help Participants use drugs safely

Each time you fill a prescription, we look for possible problems, such as drugs errors or drugs that:

- may not be needed because you are taking another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we will notify your Care Manager and have your IDT work with your provider to correct the problem.

G2. Programs to help Participants manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a Medication Therapy Management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications

- any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to Participants that qualify. If we have a program that fits your needs, your IDT will discuss whether you should enroll in the program.

If you have any questions about these programs, please contact Participant Services or your Care Manager.

G3. Drug management program (DMP) to help Participants safely use their opioid medications

PHP Care Complete FIDA-IDD Plan has a program that can help Participants safely use their prescription opioid medications and other medications that are frequently misused. This program is called a DMP.

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid *or benzodiazepine* medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor.**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9, Section F6.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: Understanding the plan's drug coverage

Introduction

This chapter discusses your outpatient drug coverage through PHP Care Complete FIDA-IDD Plan. By "drugs," we mean:

- Medicare Part D prescription drugs, **and**
- drugs and items covered under Medicaid, **and**
- drugs and items covered by the plan as additional benefits.

Because you are enrolled in the Fully Integrated Duals Advantage for people with Intellectual and Developmental Disabilities (FIDA-IDD) Demonstration, you have **no costs** for any covered drugs.

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

To learn more about prescription drugs, you can look in these places:

- PHP Care Complete FIDA-IDD Plan's *List of Covered Drugs*.
    - We call this the "Drug List." It tells you:
        - Which drugs PHP Care Complete FIDA-IDD Plan pays for
        - Which of the 3 tiers each drug is in
        - Whether there are any limits on the drugs
    - If you need a copy of the Drug List, call Participant Services. You can also find the Drug List on our website at www.phpcares.org. The Drug List on the website is always the most current.
- Chapter 5 of this *Participant Handbook*.
    - Chapter 5 tells how to get your outpatient prescription drugs through PHP Care Complete FIDA-IDD Plan.
    - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by PHP Care Complete FIDA-IDD Plan.
- PHP Care Complete FIDA-IDD Plan *Provider and Pharmacy Directory*.

- In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with PHP Care Complete FIDA-IDD Plan.
- The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5 Section A1.

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A. The Explanation of Benefits (EOB)

PHP Care Complete FIDA-IDD Plan keeps track of your drugs and your total drug costs, including the amount Medicare pays for you.

When you get prescription drugs through PHP Care Complete FIDA-IDD Plan, we send you a summary called the EOB. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what Medicare paid for you. The EOB is not a bill. It is just for your records.
- **"Year-to-date" information.** These are your drugs used during the year and the total payments made by PHP Care Complete FIDA-IDD Plan and Medicare for you since January 1.
- **Drug price information.** This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- We also pay for some over-the-counter (OTC) drugs.
- To find out which drugs PHP Care Complete FIDA-IDD Plan covers, refer to the Drug List.

B. How to keep track of your drugs

To keep track of your drugs, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Participant ID Card.

Show your Participant ID Card every time you get a prescription filled. This will help us know what prescriptions you fill.

2. Make sure we have the information we need if we need to reimburse you.

You should not have to pay for any covered drugs under PHP Care Complete FIDA-IDD Plan. In the event of a mix-up at the pharmacy or some other reason that you end up paying for a covered drug, give us copies of receipts. You can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of PHP Care Complete FIDA-IDD Plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

To learn how to ask us to pay you back for the drug, refer to Chapter 7 Section B.

3. Check the EOBs we send you.

When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, please call Participant Services. Be sure to keep these EOBs.

C. Summary of your drug coverage

C1. The plan's tiers

With PHP Care Complete FIDA-IDD Plan, *you pay nothing for covered drugs as long as you follow the plan's rules.*

Tiers are groups of drugs. Every drug on the plan's Drug List is in one of <number of tiers> tiers. There is no cost to you for drugs on any of the tiers.

- *Tier 1 drugs are generic drugs.*
- *Tier 2 drugs are brand name drugs.*
- *Tier 3 drugs are OTC drugs.*

C2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is *up to* a 90-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 Section A7 or the *Provider and Pharmacy Directory*.

C3. Your coverage for a one-month supply of a covered prescription drug

	A network pharmacy A one-month or up to a 30-day supply	**The plan's mail-order service** Up to a 90-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5 Section A8 for details.
Tier 1 *Generic Drugs Covered by Medicare Part D*	$0	$0	$0	$0
Tier 2 Brand Drugs Covered by Medicare Part D	$0	$0	$0	$0
Tier 3 Medicaid- Covered Drugs and Medicaid OTC Drugs, both Generic and Brand	$0	$0	$0	$0

For information about which pharmacies can give you long-term supplies, refer to the plan's *Provider and Pharmacy Directory*.

D. Vaccinations

PHP Care Complete FIDA-IDD Plan covers Medicare Part D vaccines. There are no costs for vaccinations that are covered under PHP Care Complete FIDA-IDD Plan.

D1. What you need to know before you get a vaccination

We recommend that you talk to your Care Manager whenever you would like to get a vaccination. Your IDT will discuss appropriate vaccinations.

- It is best to use a network provider and pharmacy to get your vaccinations. If you are not able to use a network provider and pharmacy, you may have to pay the entire cost for both the vaccine itself, a prescription drug, and for getting the vaccine.
- For example, sometimes you may get the vaccine as a shot given to you by your provider. If you are in this situation, we recommend that you call your Care Manager first. If you pay the full cost of the vaccine at a provider's office, we can tell you how to ask us to pay you back. To learn how to ask us to pay you back, refer to Chapter 7 Section B.

Chapter 7: Asking us to pay a bill you have gotten for covered services, items, or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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A. Asking PHP Care Complete FIDA-IDD Plan to pay for your services, items, or drugs

You should not get a bill for any in-network services, items, or drugs. Our network providers must bill PHP Care Complete FIDA-IDD Plan for the services, items, and drugs you already got. A network provider is a provider who works with the FIDA-IDD Plan.

If you get a bill for health care or drugs, do not pay the bill. Instead, send the bill to PHP Care Complete FIDA-IDD Plan or your Interdisciplinary Team (IDT). To send PHP Care Complete FIDA-IDD Plan or your IDT a bill, refer to Chapter 12.

- If the services, items, or drugs are covered, PHP Care Complete FIDA-IDD Plan will pay the provider directly.
- If the services, items, or drugs are covered and you already paid the bill, it is your right to be paid back.
- If the services, items, or drugs are **not** covered, PHP Care Complete FIDA-IDD Plan or your IDT will tell you. You may appeal the decision.

Contact Participant Services or your Care Manager if you have any questions. If you get a bill and you do not know what to do about it, Participant Services can help. You can also call if you want to give more information about a request for payment you already sent to PHP Care Complete FIDA-IDD Plan or your IDT.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance about your FIDA-IDD Plan coverage and rights. To contact ICAN, call 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800).

Here are examples of times when you may get a bill and may need to ask PHP Care Complete FIDA-IDD Plan or your IDT to decide if the plan will pay you back or pay the bill that you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should ask the provider to bill PHP Care Complete FIDA-IDD Plan.

- If you pay the full amount when you get the care, ask us to pay you back. Send PHP Care Complete FIDA-IDD Plan or your IDT the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send PHP Care Complete FIDA-IDD Plan or your IDT the bill and proof of any payment you made.

- If the provider should be paid, PHP Care Complete FIDA-IDD Plan will pay the provider directly.
- If you have already paid for the service, PHP Care Complete FIDA-IDD Plan will pay you back.

2. When a network provider sends you a bill

Network providers must always bill PHP Care Complete FIDA-IDD Plan. Show your PHP Care Complete FIDA-IDD Plan Participant ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Participant Services if you get any bills**.

- *Because PHP Care Complete FIDA-IDD Plan pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.*
- Whenever you get a bill from a network provider, send us the bill. PHP Care Complete FIDA-IDD Plan will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send PHP Care Complete FIDA-IDD Plan or your IDT the bill and proof of any payment you made. PHP Care Complete FIDA-IDD Plan will pay you back *for your covered services, items, and drugs.*

3. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you will have to pay the full cost of your prescription.

- In some cases, PHP Care Complete FIDA-IDD Plan or your IDT will approve prescriptions filled at out-of-network pharmacies. Send PHP Care Complete FIDA-IDD Plan or your IDT a copy of your receipt when you ask PHP Care Complete FIDA-IDD Plan to pay you back.
- Please refer to Chapter 5, Section A8 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Participant ID Card with you

If you do not have your Participant ID Card with you, you can ask the pharmacy to call PHP Care Complete FIDA-IDD Plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send PHP Care Complete FIDA-IDD Plan or your IDT a copy of your receipt when you ask PHP Care Complete FIDA-IDD Plan to pay you back.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on PHP Care Complete FIDA-IDD Plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
    - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision from PHP Care Complete FIDA-IDD Plan or your IDT Chapter 9, Section F4
    - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision from PHP Care Complete FIDA-IDD Plan or your IDT Chapter 9, Section D.
- Send PHP Care Complete FIDA-IDD Plan or your IDT a copy of your receipt when you ask for PHP Care Complete FIDA-IDD Plan to pay you back. In some situations, PHP Care Complete FIDA-IDD Plan or your IDT may need to get more information from your doctor or other prescriber in order for PHP Care Complete FIDA-IDD Plan to pay you back for the drug.

When you send PHP Care Complete FIDA-IDD Plan or your IDT a request for payment, your request will be reviewed and a decision will be made as to whether the service, item, or drug should be covered. This is called making a "coverage decision." If PHP Care Complete FIDA-IDD Plan or your IDT decides it should be covered, PHP Care Complete FIDA-IDD Plan will pay for the service, item, or drug. If PHP Care Complete FIDA-IDD Plan or your IDT denies your request for payment, you can appeal the decision.

To learn how to make an appeal, refer to Chapter 9, Section F5.

B. Sending a request for payment

Send PHP Care Complete FIDA-IDD Plan or your IDT your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** *You can ask your Care Manager for help.*

Mail your request for payment together with any bills or receipts to us at this address:

Partners Health Plan
P.O. Box 240356
Apple Valley, MN 55124

You may also call PHP Care Complete FIDA-IDD Plan *to ask for payment. Call us at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.*

C. Coverage decisions

When PHP Care Complete FIDA-IDD Plan or your IDT gets your request for payment, it will be reviewed and a coverage decision will be made. **This means that PHP Care Complete FIDA-IDD Plan or your IDT will decide whether your health care or drug is covered by the plan.** PHP Care Complete FIDA-IDD Plan or your IDT will also decide the amount, if any, you have to pay for the health care or drug.

- PHP Care Complete FIDA-IDD Plan or your IDT will let you know if it needs more information from you.
- If PHP Care Complete FIDA-IDD Plan or your IDT decides that the service, item, or drug is covered and you followed all the rules, the plan will pay for it. If you have already paid for the service, item, or drug, PHP Care Complete FIDA-IDD Plan will mail you a check for what you paid. If you have not paid for the service, item, or drug yet, PHP Care Complete FIDA-IDD Plan will pay the provider directly.

Chapter 3, Section B explains the rules for getting your services covered. Chapter 5, Section B explains the rules for getting your Medicare Part D prescription drugs covered.

- If PHP Care Complete FIDA-IDD Plan or your IDT decides the plan should not pay for the service, item, or drug, the plan will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9, Section D.

D. Appeals

If you think PHP Care Complete FIDA-IDD Plan or your IDT made a mistake in turning down your request for payment, you can ask PHP Care Complete FIDA-IDD Plan to change the decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount PHP Care Complete FIDA-IDD Plan or your IDT decides that the plan will pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9, Section D.

- If you want to make an appeal about getting paid back for a service or item, refer to Chapter 9, Section D
- If you want to make an appeal about getting paid back for a drug, refer to Chapter 9, Section D
- ICAN can also give you free information and assistance with any appeals you may file with PHP Care Complete FIDA-IDD Plan. To contact ICAN, call 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800).

Chapter 8: Your rights and responsibilities

Introduction

In this chapter, you will find your rights and responsibilities as a Participant of PHP Care Complete FIDA-IDD Plan. PHP Care Complete FIDA-IDD Plan must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about PHP Care Complete FIDA-IDD Plan benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are a Participant in PHP Care Complete FIDA-IDD Plan. We must also tell you about all of your rights and how to exercise your rights in writing prior to the effective date of coverage.

- You have the right to get timely information about PHP Care Complete FIDA-IDD Plan changes. This includes the right to get annual updates to the Marketing, Outreach and Participant Communications materials.
- This also means you have the right to get notice of any significant change in the way in which services are provided to you at least 30 days prior to the intended effective date of the change.
- You have the right to have all plan options, rules, and benefits fully explained, including through the use of a qualified interpreter if needed. To get information in a way that you can understand, please call Participant Services. PHP Care Complete FIDA-IDD Plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials *in languages other than English and* in formats such as large print, braille, or audio. PHP Care Complete FIDA-IDD Plan offers materials in English, Spanish, Chinese, and Russian. You can make a standing request to get materials, now and in the future, in a language other than English or in an alternative format by calling Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.
- If you are having trouble getting information from PHP Care Complete FIDA-IDD Plan because of language problems or a disability and you want to file a grievance, call:
- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Medicaid at NYS Department of Health, Bureau of Managed Care Certification and Surveillance at 1-800-206-8125.
- You can also call your local Office for Civil Rights. You may also reach them at: Jacob Javits Federal Building, 26 Federal Plaza - Suite 3312, New York, NY 10278.

- If you have a disability and need help getting care or reaching a provider, call Participant Services. If you have a grievance, such as a problem with wheelchair access, Participant Services can help. You can reach Participant Services 1-855-747-5483, 8AM to 8PM, seven days a week. TTY users call 711.

- **Tiene derecho a obtener información de manera que cumpla consus necesidades**

- Debemos informarle acerca de los beneficios del Plan de Ventaja Doble Completamente

- Integrado y para Personas con Discapacidades de Desarrollo e Intelectuales (FIDA-IDD)
- PHP Care Complete, y de sus derechos de manera que usted pueda comprenderlos.
- Debemos informarle acerca de sus derechos cada año que participa en el Plan FIDA-IDD
- PHP Care Complete. También debemos informarle sobre todos sus derechos y cómo
- ejercerlos por escrito antes de la fecha de entrada en vigencia de la cobertura.

- Tiene derecho a recibir información oportuna acerca de los cambios del Plan FIDA-IDD PHP Care Complete. Esto incluye el derecho a recibir actualizaciones anuales de los materiales de Mercadeo, Alcance y Comunicaciones a los participantes. Esto también significa que usted tiene derecho a recibir una notificación respecto de cualquier cambio significativo en la manera en que se le brindan los servicios con, al menos, 30 días de anticipación a la fecha de entrada en vigencia estimada del cambio.

- Tiene derecho a que se le expliquen por completo todas las opciones, las normas y los beneficios del plan, incluida la explicación mediante el uso de un intérprete cualificado si fuera necesario. Para obtener información de manera que pueda comprenderla, llame a Servicios para el participante. El Plan FIDA-IDD PHP Care Complete tiene personas que
- pueden responder preguntas en diferentes idiomas.

- Nuestro plan también puede brindarle acceso a materiales en otros idiomas además de inglés y en formatos tales como letras grandes, braille o audio. El Plan FIDA-IDD PHP Care Complete brinda materiales en inglés, español, chino y ruso.

- Puede hacer una solicitud para obtener materiales, ahora y más adelante, en un idioma que no sea inglés o en un formato alternativo llamando a Servicios para el participante al 1-855-747-5483 y al 711 para los usuarios de TTY durante el horario de 8:00 a. m. a 8:00 p. m., los siete días de la semana.

- Si tiene dificultades para obtener información del Plan FIDA-IDD PHP Care Complete debido a problemas con el idioma o a una discapacidad y quiere presentar un reclamo, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede comunicarse con la Oficina de Certificación y Control de la Atención Administrada (Bureau of Managed Care Certification and Surveillance) del Departamento de Salud del Estado de Nueva York al 1-800-206-

- **您有權透過符合您需求的方式取得資訊**

- **我們必須透過您能夠瞭解的方式向您說明 PHP Care Complete FIDA-IDD Plan 的福利以及您的權利。在您參加 PHP Care Complete FIDA-IDD Plan 期間，我們每年皆必須向您說明您的權利。此外，我們也必須在承保生效日期前，透過書面方式向您說明您所有的權利以及行使權利的方式。**
- **您有權即時獲得有關 PHP Care Complete FIDA-IDD Plan 變更的資訊。這包括您有權獲得行銷、推廣以及參與者通訊資料的年度更新資訊。這也表示，如果本計畫為您提供服務的方式有任何重大變更，您有權在變更預計生效日期至少 30 天前接獲通知。**

- **您有權獲得所有計畫選項、規定及福利的完整說明，包括在需要時使用合格的口譯人員。若要透過您能夠瞭解的方式取得資訊，請致電參與者服務部。PHP Care Complete FIDA-IDD Plan 有可使用不同語言回答問題的工作人員。**

- **本計畫亦可為您提供英文以外之其他語言版本和諸如大字版、盲文版或語音版等格式的資料。PHP Care Complete FIDA-IDD Plan 提供英文版、西班牙文版、中文版及俄文版的資料**
- **您**可致電參與者服務部提出長期申請，以在現在及未來取得英語以外之其他語言版本或其他格式的資料，電話：1-855-747-5483，聽障專線 (TTY) 使用者請致電 711，服務時間為每週七天，上午 8 時至晚上 8 時。

- 如果您因為語言問題或因為您是殘障人士而無法透過 PHP Care Complete FIDA-IDD Plan 取得資訊，並且想提出申訴，請致電 1-800-MEDICARE (1-800-633-4227) 與 Medicare 聯絡。您每週 7 天，每天 24 小時均可致電。聽障專線 (TTY) 使用者請致電 1-877-486-2048。您也可撥打 1-800-206-8125 與紐約州衛生署的管理式照護認證與監管局 (Bureau of Managed Care Certification and Surveillance) 聯絡。

- **Вы имеете право получать необходимую информацию в удобном и доступном для вас виде**

- Мы должны понятным для вас языком объяснять, какое обслуживание покрывает план PHP Care Complete FIDA-IDD и какие у вас есть права. Пока вы остаетесь участником плана PHP Care Complete FIDA-IDD, мы должны

сообщать вам о ваших правах ежегодно. Кроме того, к началу страхового покрытия по нашему плану мы должны в письменной форме сообщить вам обо всех ваших правах и о том, как ими пользоваться.

- Вы имеете право своевременно узнавать об изменениях в работе плана PHP Care Complete FIDA-IDD. в том числе ежегодно получать обновленные материалы по вопросам маркетинга и взаимодействия с участниками плана. Кроме того, вы имеете право получать уведомления обо всех существенных изменениях в том,

- Кроме того, материалы нашего плана можно получатьв переводе на иностранные языки и в альтернативных формах, например, напечатанными крупным шрифтом, шрифтом Брайля или в виде аудиозаписи. План PHP Care Complete FIDA-IDD Plan предлагает материалы на английском, испанском, китайском и русском языках.

- Вы можете попросить о том, чтобы вам всегда, и сейчас, и в будущем, присылали материалы плана в переводе на ваш язык или в альтернативном формате. Для этого позвоните в отдел обслуживания участников по телефону 1-855-747-5483, а пользователи TTY могут звонить по телефону 711, с 8:00 до 20:00 в любой день недели.

- Если из-за языкового барьера или инвалидности вам трудно разбираться в информации, которую вам сообщает план PHP Care Complete FIDA-IDD, вы можете подать жалобу. Для этого позвоните в программу Medicare по телефону 1-800-MEDICARE (1-800-633-4227). Линия работает круглосуточно и без выходных. Пользователям TTY следует звонить по телефону 1-877-486-2048. Вы также можете обратиться в Бюро сертификации и надзора над предоставлением управляемого обслуживания (Bureau of Managed Care Certification and Surveillance) при Департаменте здравоохранения штата Нью-Йорк (NYS Department of Health) по телефону 1-800-206-8125.

B. Our responsibility to ensure that you get timely access to covered services, items, and drugs

As a Participant of PHP Care Complete FIDA-IDD Plan these are your rights:

- You have the right to get medically necessary services, items, and drugs as required to meet your needs, in a way that is sensitive to your language and

culture, and that is provided in an appropriate care setting, including the home and community.

- You have the right to choose a Primary Care Provider (PCP) in PHP Care Complete FIDA-IDD Plan's network. A network provider is a provider who works with PHP Care Complete FIDA-IDD Plan. You can also ask us to have a specialist serve as your PCP. You can find more information about choosing a PCP in Chapter 3 Section E.
    - Call Participant Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which providers are accepting new patients.
- You have the right to make decisions about providers and coverage, which includes the right to choose and change providers within our network.
- You have the right to a women's health specialist without getting a referral or prior authorization (PA).
    - A referral is approval from your PCP to use someone that is not your PCP. Referrals are not required in PHP Care Complete FIDA-IDD Plan.
    - PA means that you must get approval from your Interdisciplinary Team (IDT), PHP Care Complete FIDA-IDD Plan, or another specified provider before you can get certain services, items, or drugs or use an out-of-network provider.
- You have the right to access other services that do not require PA, such as emergency and urgently needed care, out-of-area dialysis services, and PCP visits. Please refer to Chapter 4 *Section D* for more information on services requiring PA and those that do not.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to have telephone access to your providers through on-call services. You also have the right to access the PHP Care Complete FIDA-IDD Nurse Advice Call Line 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care or assistance.

- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to access care without facing physical barriers. This includes the right to be able to get in and out of a provider's office, including barrier-free access if you have any disabilities or other conditions limiting your mobility, in accordance with the Americans with Disabilities Act.
- You have the right to access an adequate network of primary and specialty providers who are available and capable of meeting your needs with respect to physical access, as well as communication and scheduling needs.
- You have the right to get reasonable accommodations in accessing care, in interacting with PHP Care Complete FIDA-IDD Plan and providers, and in getting information about your care and coverage.
- You have the right to be told where, when, and how to get the services you need, including how to get covered benefits from out-of-network providers if the providers you need are not available in PHP Care Complete FIDA-IDD Plan's network. To learn about out-of-network providers, refer to Chapter 3 Section E4.

Chapter 9 Section C explains what you can do if you think you are not getting your services, items, or drugs within a reasonable amount of time. Chapter 9 Section C also tells you what you can do if we have denied coverage for your services, items, or drugs and you do not agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

You have the right to have privacy during treatment and to expect confidentiality of all records and communications.

Your PHI includes the information you gave us when you enrolled in PHP Care Complete FIDA-IDD Plan. It also includes your conversations with your providers, your medical records, and other medical and health information.

You have the right related to your information and to control how your PHI is used. We give you a written notice called the "Notice of Privacy Practice" that tells about these rights. The notice also explains how we protect the privacy of your PHI.

You have the right to ask that any communication that contains protected PHI from PHP Care Complete FIDA-IDD Plan be sent by alternative means or to an alternative address.

C1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

Except for the cases noted below, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare and Medicaid your PHI and drug information. If Medicare or Medicaid releases your PHI for research or other uses, it will be done according to Federal laws. You have the right to ask for information on how your health and other information has been released by PHP Care Complete FIDA-IDD Plan.

C2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Participant Services at Participant Services at 1-855-747-5483, 8AM to 8PM, seven days a week. TTY users call 711.

D. Our responsibility to give you information about PHP Care Complete FIDA-IDD Plan, its network providers, and your covered services

As a Participant of PHP Care Complete FIDA-IDD Plan, you have the right to get timely information and updates from us. If you do not speak English, we must give you the information free of charge in a language that you can understand.

- We must also provide you with a qualified interpreter, free of charge, if you need one during appointments with providers.

- If you have questions about PHP Care Complete FIDA-IDD Plan or you are in need of interpreter services, just call us at 1-855-747-5483. This is a free service.
- We offer written materials in English, Spanish, Chinese, and Russian.
- We can also give you information in other formats, like large print, braille, or audio. To request materials in languages other than English or in other formats, call our Participant Call Center at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

If you want information about any of the following, call Participant Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how PHP Care Complete FIDA-IDD Plan has been rated by plan Participants
  - the number of appeals made by Participants
  - how to leave PHP Care Complete FIDA-IDD Plan
- Our network providers and our network pharmacies, including:
  - how to choose or change PCPs
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - a list of providers and pharmacies in PHP Care Complete FIDA-IDD Plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Participant Services, or visit our website at www.phpcares.org.
- Covered services (refer to Chapter 3 and 4), items, and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
  - services, items, and drugs covered by PHP Care Complete FIDA-IDD Plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services, items, and drugs

- Why a service, item, or drug is not covered and what you can do about it (refer to Chapter 9), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services, items, or drugs. They also cannot charge you if we pay less than the provider charged us or if we don't pay them at all. You have the right to not be charged any copays, premiums, deductibles, or other cost-sharing. To learn what to do if a network provider tries to charge you for covered services, items, or drugs, refer to Chapter 7 Section A or call Participant Services.

F. Your right to leave PHP Care Complete FIDA-IDD Plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10 Section B for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- *You will get your Medicaid services through Medicaid Fee-For-Service (Original Medicaid).*

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your services

You have the right to get full information from your doctors and other health care providers. You also have the right to have access to doctors and other providers who can meet your needs. This includes providers who can help you meet your health care needs, communicate with you in a way that you can understand, and provide you with services in locations that you can physically access. You may also choose to have a

family member or caregiver involved in your services and treatment discussions. You have the right to appoint someone to speak for you about the care you need. You have the right to:

- **Know your choices.** You have the right to be told about all the kinds of treatment. You have the right to talk with and get information from providers on all available treatment options and alternatives, regardless of cost, and to have these options presented in a way you understand.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another provider before deciding on treatment.
- **Say "no."** You have the right to accept or refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your provider advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from PHP Care Complete FIDA-IDD Plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **Get a written explanation.** If covered services, items, or drugs were denied, you have the right to get a written explanation without having to ask for one.
- **Ask us to cover a service item, or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 Section E tells how to ask PHP Care Complete FIDA-IDD Plan or your IDT for a coverage decision.
- **Participate in your care planning.** As a Participant in PHP Care Complete FIDA-IDD Plan, you will get a comprehensive assessment upon enrollment. You will also meet with your IDT to develop your Life Plan and to update it, when necessary. You have the right to ask for a new comprehensive assessment or an update to your Life Plan at any time. For more information, refer to Chapter 1 Section G.
- Get complete and accurate information related to your health and functional status from your provider, your IDT, and PHP Care Complete FIDA-IDD Plan.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to give someone the right to make health care decisions for you.
- **Give your providers written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care. When you enroll in the plan, we will inform you about your right to make an advance directive. You will also be told about this right when your Life Plan is updated.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your PCP, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid may also have advance directive forms. *You can also contact Participant Services to ask for the forms.*
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your PCP. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

G3. What to do if your instructions are not followed

PHP Care Complete FIDA-IDD Plan and our providers must honor your instructions. If you have signed an advance directive, and you believe that a provider did not follow the instructions in it, you may file a complaint with the New York State Department of Health Hospital Complaint Line at 1-800-804-5447 or the Managed Long Term Care Technical Assistance Center at 1-866-712-7197.

H. Your right to ask for help

Chapter 2 contains contact numbers for many helpful resources. You have the right to ask for help without interference from PHP Care Complete FIDA-IDD Plan. You can ask for help from agencies like the Independent Consumer Advocacy Network (ICAN) or the NY State Long Term Care Ombudsman.

- ICAN can provide information and assistance related to your PHP Care Complete FIDA-IDD Plan coverage. ICAN can be reached at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800).
- The NY State Long Term Care Ombudsman can provide information and assistance regarding your rights as a resident of a long-term care facility. Call 1-800-342-9871 for information about contacting your local long-term care ombudsman.

There are other resources available to you, including those listed in Chapter 2. You have the right to ask for help from the entities listed in Chapter 2 or from any other entity you identify.

I. Your right to file a grievance and to ask us to reconsider decisions we have made

Chapter 9 Section E tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or file a grievance.

You have the right to get information about appeals and grievances that other Participants have filed against PHP Care Complete FIDA-IDD Plan. To get this information, call Participant Services.

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed in Chapter 11 – or you would like more information about your rights, you can get help by calling:

- Participant Services and file a grievance with PHP Care Complete FIDA-IDD Plan as outlined in Chapter 9 Section J.

- You can call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- Medicaid at 1-800-541-2831. TTY users call 1-877-898-5849.
- You can call ICAN at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800).

Under all circumstances, you have the right to file an internal grievance with PHP Care Complete FIDA-IDD Plan, an external grievance with Medicare or the New York State Department of Health (NYSDOH), or an appeal of any coverage decision. The processes for filing any of these are outlined in Chapter 9 Sections C, D, J.

I2. How to get help understanding your rights or exercising them

You can call ICAN at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800). ICAN provides free information and assistance. It is not affiliated with our plan.

J. Your right to suggest changes

You have the right to recommend changes in policies and services to PHP Care Complete FIDA-IDD Plan, Medicare, NYSDOH, Office for People With Developmental Disabilities (OPWDD) or any outside representative of your choice.

K. Your responsibilities as a Participant of PHP Care Complete FIDA-IDD Plan

As a Participant of PHP Care Complete FIDA-IDD Plan, you have a responsibility to do the things that are listed below. If you have any questions, call Participant Services.

- **Read the *Participant Handbook*** to learn what is covered and what rules you need to follow to get covered services, items, and drugs. This includes choosing a PCP and using network providers for covered services, items, and drugs. If you don't understand something, call Participant Services. For details about your:

  - Covered services and items, refer to Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6.

- **Tell us about any other health or prescription drug coverage you have.** We are required to make sure you are using all of your coverage options when you get health care. Please call Participant Services if you have other coverage.
- **Tell your PCP and other providers** that you are enrolled in our plan. Show your Participant ID Card whenever you get services, items, or drugs.
- **Help your PCP** and other providers give you the best care.
  - Call your PCP or Care Manager if you are sick or injured for direction right away. When you need emergency care from out-of-network providers, notify PHP Care Complete FIDA-IDD Plan as soon as possible. In case of emergency, call 911.
  - Give your providers the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure that your PCP and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter (OTC) drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
  - Understand the role of your PCP, your Care Manager, and your IDT in providing your care and arranging other health care services that you may need.
  - Participate in the development of your Life Plan with your IDT and keep appointments or notify your Care Manager or IDT if an appointment cannot be met.
- **Be considerate.** We expect all of our Participants to respect the rights of other Participants. We also expect you to act with respect in your PCPs office, hospitals,

other providers' offices, and when dealing with PHP Care Complete FIDA-IDD Plan employees.

Pay what you owe. As a PHP Care Complete FIDA-IDD Plan Participant, you are responsible for paying the full cost of any services, items, or drugs that are not covered by the plan.

- If you disagree with your IDT's decision or PHP Care Complete FIDA-IDD Plan's decision to not cover a service, item, or drug, you can make an appeal. Please refer to Chapter 9 Section E to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Participant Services.
  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get PHP Care Complete FIDA-IDD Plan. Chapter 1 Section D tells about our service area.
  - New York Medicaid Choice can help you figure out whether you are moving outside our service area and can help you identify alternative Medicare and Medicaid coverage.
  - Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Medicaid.
  - **If you move within our service area, we still need to know.** We need to keep your participation record up to date and know how to contact you.
- Tell us if you have any changes in your personal information, including your income or assets. You must provide PHP Care Complete FIDA-IDD Plan with accurate and complete information.
  - It is important to tell us right away if you have a change in personal information such as phone number, address, marital status, additions to your family, eligibility, or other health insurance coverage.
  - If your assets in bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, or any other assets change, please notify Participant Services and New York State.
- Call Participant Services for help if you have any questions or concerns. Let us know about any problems immediately.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, grievances)

Introduction

This chapter has information about coverage decisions and your grievance and appeal rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or drug that your IDT or plan has said the plan will not pay for.
- You disagree with a decision that your IDT or plan has made about your care.
- You think your covered services and items are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find information about what to do for your problem or concern.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your IDT determines are necessary for your care, whether included in your Life Plan or because a need arose outside of your Life Plan. **If you are having a problem with your care, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800 for help.** This chapter explains the different options you have for different problems and complaints, but you can always call ICAN to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, refer to Chapter 2 for more information on ombudsman programs.

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A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. About the legal terms

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Coverage decision" rather than "organization determination," "benefit determination," "at-risk determination," or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Understanding and knowing the meaning of the proper legal terms can help you communicate more clearly, so we provide those too.

B. Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Independent Consumer Advocacy Network

If you need help, you can always call ICAN. The state created ICAN, which is an ombudsman program that helps you with appeals and other issues. ICAN can answer your questions and help you understand what to do to handle your problem. Refer to Chapter 2 for more information on ombudsman programs.

ICAN is not connected with us or with any insurance company or health plan. ICAN can help you understand your rights and how to share your concerns or disagreement. ICAN can also help you in communicating your concerns or disagreement with us. The toll-free phone number for ICAN is 1-844-614-8800. The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call the SHIP, a state program that gets funding from the federal government. In New York State, the SHIP is called the Health Insurance Information, Counseling, and Assistance Program (HIICAP). HIICAP counselors can answer your questions and help you understand what to do to handle your problem. HIICAP is not connected with us or with any insurance company or health plan. HIICAP has trained counselors and services are free. The phone number for HIICAP is 1-800-701-0501 and their website is aging.ny.gov.

Getting help from Medicare

You can also call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- Visit the Medicare website (www.medicare.gov).

C. Problems with your coverage

C1. Deciding whether you should file an appeal or a grievance

If you have a problem or concern, you only need to read the parts of this chapter that describe the process for your type of concern. The chart below will help you find the right section of this chapter for appeals and grievances.

Is your problem or concern about your coverage? (This includes problems about whether particular services, items, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for services, items, or prescription drugs.)	
Yes. My problem is about coverage. Refer to **Section D: "Coverage decisions and appeals"**	**No.** My problem is not about coverage. Skip ahead to **Section J: "How to file a grievance"**

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

What is a coverage decision?

A coverage decision is an initial decision your IDT, the plan, or an authorized specialist makes about your benefits and coverage or about the amount the plan will pay for your medical services, items, or drugs. The IDT, plan, or authorized specialist is making a coverage decision whenever it decides what is covered for you and how much the plan will pay. Authorized specialists include dentists, optometrists, ophthalmologists, and audiologists.

If you or your provider is not sure if a service, item, or drug is covered by the plan, either of you can ask for a coverage decision before the provider gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review a decision made by your IDT, the plan, or an authorized specialist and change it if you think a mistake was made. For example, the IDT, plan, or authorized specialist might decide that a service, item, or drug that you want is not covered. If you or your provider disagree with that decision, you can appeal.

NOTE: You are a member of your IDT. You can appeal even if you participated in the discussions that led to the coverage decision that you wish to appeal.

D2. Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Participant Services** at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.
- Call your **Care Manager** at the phone number listed on the front of your Participant ID Card.
- Call **ICAN** for free help. ICAN is an independent organization. It is not connected with this plan. The phone number is 1-844-614-8800.
- Call **HIICAP** for free help. HIICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-701-0501.

- Talk to **your provider**. Your provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - Anyone can help you request a coverage determination or an appeal.
    - Only someone you designate in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can either complete an "Appointment of Representative" form or you can write and sign a letter indicating who you want to be your representative.
        - » To get an "Appointment of Representative" form, you can call Participant Services.
        - » You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf The form gives the person permission to act for you. You must give us a copy of the signed form; **OR**
        - » You can write a letter and either send it to us or have the person listed in the letter as your representative send it to us.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
    - However, **you do not need to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E** gives you information on what to do if you have problems about services, items, and drugs (but **not** Medicare Part D drugs). For example, use this section if:

- You are not getting medical care you want, and you believe the plan covers this care.
- The IDT, plan, or authorized specialist did not approve services, items, or drugs that your provider wants to give you, and you believe this care should be covered.
  - » **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with a **DP (Dual Program)** are **not** covered by Part D. Refer to Section F for instructions about the Part D drug appeals process.
- You got services or items you think should be covered, but the IDT, plan, or authorized specialist decided that the plan will not pay for this care.
- You got and paid for services or items that you thought were covered, and you want the plan to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with the decision.
  - » **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H
- Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- **Section F** gives you information about Part D drugs. For example, use this section if:
  - You want to ask the plan or your IDT to make an exception to cover a Part D drug that is not on the plan's Drug List.
  - You want to ask the plan or your IDT to waive limits on the amount of the drug you can get.

- You want to ask the plan or your IDT to cover a drug that requires prior authorization (PA) or approval.
- The plan or your IDT did not approve your request or exception, and you or your provider think we should have.
- You want to ask the plan to pay for a prescription drug you already bought. (This is asking the plan or your IDT for a coverage decision about payment.)

- **Section G** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the provider is discharging you too soon. Use this section if:
  - You are in the hospital and think the provider asked you to leave the hospital too soon.
- **Section H** gives you information if you think your home health care, SNF care, and CORF services are ending too soon.

If you're not sure which section you should use, please call Participant Services at <phone number>.

If you need other help or information, please call ICAN at 1-844-614-8800.

E. Problems about services, items, and drugs (but not Medicare Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your coverage for your medical, behavioral health, and long-term care services. You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with a **DP (Dual Program)** are **not** covered by Part D. Use Section F of this chapter for information about Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. You think the plan covers a medical, behavioral health, or long-term care service that you need but are not getting.

   What you can do: You can ask your IDT, the plan, or an authorized specialist to make a coverage decision. Refer to Section E2 for information on asking for a coverage decision. If you disagree with that coverage decision, you can file an appeal.

2. The IDT, plan, or authorized specialist did not approve care your provider wants to give you, and you think it should have.

What you can do: You can appeal the decision to not approve your services. Refer to Section E3 for information on making an appeal.

3. You got services or items that you think the plan covers, but the IDT, plan, or authorized specialist decided that the plan will not pay.

   What you can do: You can appeal the decision that the plan will not pay. Refer to Section E3 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want the plan to reimburse you for the services or items.

   What you can do: You can ask the IDT, plan, or authorized specialist to authorize the plan to pay you back. Refer to Section E5 for information on asking for payment.

5. The IDT, plan, or authorized specialist changed or stopped your coverage for a certain service, and you disagree with the decision.

   What you can do: You can appeal the decision to change or stop the service. Refer to Section E3 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, SNF care, or CORF services, special rules apply. Read Sections G or H to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health, or long-term care service

If there is a service, item, or drug that you feel you need, ask your IDT, the plan, or an authorized specialist to approve that service, item, or drug for you. You can do this by contacting your Care Manager and telling him/her that you want a coverage decision. Or you can call, write, or fax us, or ask your representative or provider to contact us and ask for a coverage decision.

- You can call us at: 1-855-747-5483. TTY users call: 711.
- You can fax us at: 1-855-769-2509.
- You can write to us at: 2500 Halsey Street, Bronx, NY 10461

Once you've asked, the IDT, plan, or authorized specialist will make a coverage decision.

How long does it take to get a coverage decision?

It usually takes up to 3 business days after you asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no

more than 72 hours after we receive your request. If you do not receive a decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes the IDT, plan, or authorized specialist needs more time to make a decision. In this case, you will get a letter telling you that it could take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

There are three exceptions to the decision deadline described above:

- For coverage decisions about continuing or adding to your current health care services, you will get a decision within 1 business day.
- For coverage decisions about home health care services after an inpatient hospital stay, you will get a decision within 1 business day. However, if the day after your request is a weekend or holiday, you will get a decision within 72 hours.
- For coverage decisions on a service, item, or drug that you already got, you will get a decision within 14 calendar days.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask for a "fast coverage decision." If the IDT, plan, or authorized specialist approves the request, you will get a decision within 24 hours. The 24-hour limit also applies to Medicare Part B prescription drugs.

However, sometimes the IDT, plan, or authorized specialist needs more time. In this case, you will get a letter telling you that it could take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

> The **legal term** for "fast coverage decision" is **"expedited determination."**

If you want to ask for a fast coverage decision, you can do one of three things:

- Call your Care Manager;
- Call Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week or fax us at 1-855-769-2509; **or**
- Have your provider or your representative call Participant Services.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for a service, item, or drug you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for a service, item, or drug you already got.)

2. You can get a fast coverage decision **only if the standard 3 business day deadline (or the 72-hour deadline for Medicare Part B prescription drugs) could seriously jeopardize your life, health, or ability to attain, maintain or regain maximum function.**

    - If your provider says that you need a fast coverage decision, you will automatically get one.

    - If you ask for a fast coverage decision without your provider's support, the IDT, plan, or authorized specialist will decide if you get a fast coverage decision.

        - If the IDT, plan, or authorized specialist decides that your health does not meet the requirements for a fast coverage decision, you will get a letter. The IDT, plan, or authorized specialist will also use the standard 3 business day deadline (or the 72-hour deadline for Medicare Part B prescription drugs) instead.

        - This letter will tell you that if your provider asks for the fast coverage decision, you will automatically get a fast coverage decision.

        - The letter will also tell how you can file a "fast grievance" about the decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for filing grievances, including fast grievances, refer to Section J.

If the coverage decision is No, how will I find out?

If the answer is **No**, you will receive a letter explaining why. The plan or your IDT will also notify you by phone.

- If the IDT, plan, or authorized specialist says **No**, you have the right to ask us to change the decision. You can do this by making (or "filing") an appeal. Making an appeal means asking our plan to review the decision to deny coverage.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

E3. Level 1 Appeal for services, items, and drugs (but not Medicare Part D drugs)

What is an appeal?

An appeal is a formal way of asking us to review the coverage decision and change it if you think there was a mistake. If you or your provider disagree with the decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call ICAN at 1-844-614-8800. ICAN is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to PHP Care Complete FIDA-IDD Plan. Our plan will review your coverage decision to check if it is correct. The reviewer will be someone at our plan who is not part of your IDT and was not involved in the original coverage decision. When we complete the review, we will give you our decision in writing. If you need a fast decision because of your health, we will also try to notify you by phone.

If we do not decide the Level 1 Appeal in your favor, we will automatically forward your appeal to the Office of Administrative Hearings (OAH) for a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your provider, or your representative must contact us. You can call us at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week, or fax us at 1-855-769-2509; or you may appeal in writing. For additional details on how to reach us for appeals, refer to Chapter 2
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a fast appeal, you should call us at 1-855-747-5483. TTY users should call 711.
- If you are asking for a standard appeal, make your appeal in writing or call us.
    - You may use the Appeal Request Form that is attached to the Coverage Determination Notice.

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. *You may also ask for an appeal by calling us.*

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because you were told that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

- You can submit a request to the following address: PHP Care Complete FIDA-IDD Plan, Appeals Department, 222 W. Las Colinas Blvd., Ste 500N, Irving, TX 75039.
- You may also ask for an appeal by calling us at 1-855-747-5483. TTY users should call 711.

> The **legal term** for "fast appeal" is **"expedited appeal."**

Can someone else make the appeal for me?

Yes. Anyone can make the appeal for you, but only someone you designate in writing can represent you during your appeal. To make someone your representative, you must complete an "Appointment of Representative" form or write and sign a letter indicating who you want to be your representative. The form or letter gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- To get an "Appointment of Representative" form, call Participant Services and ask for the form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.The form gives the person permission to act for you. You must give us a copy of the signed form; **OR**
- You can write a letter and either send it to us or have the person listed in the letter as your representative send it to us.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter that you received informing you of the coverage decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because you were told that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 Appeals" for more information.

Can I get a copy of my case file?

Yes. Call Participant Services at 1-855-747-5483 and 711 for TTY users and ask for a copy of your case file. We will provide a copy of your case file at no cost to you.

Can my provider give you more information about my appeal?

Yes, you and your provider may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of services or items. Then, we check if all the rules were followed when the IDT, plan, or authorized specialist said **No** to your request. The reviewer will be someone who is not on your IDT and was not involved in making the original decision.

If we need more information, we may ask you or your provider for it.

When will I hear about a "standard" appeal decision?

If your appeal is about Medicaid prescription drugs or a Medicare Part B prescription drug, we must give you our answer within 7 calendar days from the date we received the appeal. For all other appeals, we must give you our answer within 30 calendar days from the date we received the appeal. We will give you our decision sooner if your health condition requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take additional time to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra time, you can file a "fast grievance" about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, refer to Section J
- If we do not give you an answer to your "standard" appeal within 7 calendar days (for Medicaid prescription drug appeals or Medicare Part B prescription drug appeals) or 30 calendar days (for all other appeals), or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens. For more information about the Level 2 Appeal process, refer to Section E4

If our answer is Yes to part or all of what you asked for, we must approve the coverage within 7 calendar days after we get your Medicaid prescription drug appeal or Medicare Part B prescription drug appeal or 30 calendar days after we get your other type of appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. The letter will tell you that we sent your case to the OAH for a Level 2 Appeal. For more information about the Level 2 Appeal process, refer to Section E4

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you an answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra time to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra time, you can file a "fast grievance" about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, refer to Section J.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens. For more information about the Level 2 Appeal process, refer to Section E4

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

If our answer is No to part or all of what you asked for, we will try to contact you by phone or in person. We will also send you a letter. The letter will tell you that we sent your case to the OAH for a Level 2 Appeal. For more information about the Level 2 Appeal process, refer to Section E4.

Will my benefits continue during Level 1 Appeals?

If the IDT, plan, or authorized specialist decided to change or stop coverage for a service, item, or drug that you currently get, we will send you a notice before taking the proposed action.

If you disagree with the action, you can file a Level 1 Appeal. We will continue covering the service, item, or drug if you ask for a Level 1 Appeal **within 10 calendar days of the postmark date on our notice or by the intended effective date of the action**, whichever is later.

If you meet this deadline, you can keep getting the service, item, or drug with no changes while your appeal is pending. All other services, items, or drugs (that are not the subject of your appeal) will also continue with no changes.

E4. Level 2 Appeal for services, items, and drugs (but not Medicare Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will automatically send your case to Level 2 of the appeals process for review by the OAH.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by the OAH. The OAH is an independent organization that is not connected to PHP Care Complete FIDA-IDD Plan. The OAH is part of the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA).

What will happen at the Level 2 Appeal?

We will automatically send any Level 1 denials (in whole or in part) to the OAH for a Level 2 Appeal. We will notify you that your case was sent to Level 2 and that the OAH will be in touch. The notice will also provide the contact information for the OAH in the event that you do not hear from them to schedule your Level 2 Appeal hearing. You should receive a Notice of Administrative Hearing from the OAH at least 10 calendar days before your hearing date. Your hearing will be conducted by a Hearing Officer in-person or on the phone. You may ask us for a free copy of your case file by calling Participant Services at 1-855-747-5483 and 711 for TTY users.

Your Level 2 Appeal will either be a "standard" appeal or it will be a "fast" appeal. If you had a fast appeal at Level 1, you will automatically have a fast appeal at Level 2. Additionally, if the OAH determines that you need a fast appeal, they will give you one. Otherwise, you will have a standard appeal.

Standard Level 2 Appeal: If your standard appeal is about Medicaid prescription drugs or a Medicare Part B prescription drug, the OAH must give you an answer within 7 calendar days of when it gets your appeal. For all other standard appeals, the OAH must give you an answer within *62* calendar days from the date you asked for an appeal with our plan. The OAH will give you a decision sooner if your health condition requires it.

Fast Level 2 Appeal: The OAH must give you an answer within 72 hours of when it gets your appeal.

Will my benefits continue during Level 2 Appeals?

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. For information about continuing your benefits refer to Level 1 Appeals.

All other services, items, and drugs (that are not the subject of your appeal) will also continue without any changes.

How will I find out about the decision?

When the OAH makes a decision, it will send you a letter that explains its decision and provides information about your further appeal rights. If you qualified for a fast appeal, the OAH will also tell you the decision by phone.

- If the OAH says **Yes** to part or all of what you asked for, we must authorize the items or services immediately (within no more than 1 business day from the date of the decision).
- If the OAH says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 1 business day after we get the OAH's decision.
- If the OAH says **No** to part or all of what you asked for, it means that they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal." You can further appeal the OAH's decision.

If the IAHO's decision is No for all or part of what I asked for, can I make another appeal?

If you disagree with the OAH's decision, you may appeal that decision further to the Medicare Appeals Council (MAC) for a Level 3 Appeal. The OAH's decision is not automatically forwarded to the MAC. Instead, you will have to request that appeal. Instructions on how to file an appeal with the MAC will be included in the OAH's decision notice.

Refer to Section I for more information on additional levels of appeal.

E5. Payment problems

PHP Care Complete FIDA-IDD Plan has rules for getting services, items, and drugs. One of the rules is that the services, items, and drugs that you get must be covered by our plan. Another rule is that you must get your services, items, and drugs from providers that our plan works with. Additionally, there are sometimes rules requiring that you get approval to get an item or service before you get it. Chapter 3 explains the rules, including special rules for when you first join the plan. If you follow all of the rules, then we will pay for your services, items, and drugs.

If you are not sure if we will pay for a service, item, or drug, ask your Care Manager. Your Care Manager will be able to tell you if we will likely pay for the service, item, or drug, or if you need to ask us for a coverage decision.

If you choose to get a service, item, or drug that is not covered by our plan, or if you get a service, item, or drug from a provider that our plan does not work with, then we will not automatically pay for the service, item, or drug. In that case, you may have to pay for the service, item, or drug yourself.

If you want to ask us for payment, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services, items, or drugs." Chapter 7 describes the situations in which you may need to ask us for

reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

What if I followed the rules for getting services, items, and drugs, but I got a bill from a provider?

We do not allow providers to bill you for covered services, items, and drugs. This is true even if we pay the provider less than the provider charges for a covered service, item, or drug. You are never required to pay the balance of any bill.

If you get a bill for covered services, items, or drugs, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

Can I ask to be paid back for a service, item, or drug I paid for?

Remember, if you get a bill for a covered service, item, or drug, you should not pay the bill yourself. But if you are billed by mistake and pay the bill, you can get a refund if you followed the rules for getting services, items, and drugs.

If you are asking to be paid back, you are asking the plan or your IDT for a coverage decision. The plan or your IDT will decide if the service, item, or drug you paid for is covered, and will check if you followed all the rules for using your coverage.

- If the service, item, or drug you paid for is covered and you followed all the rules, we will reimburse you for the cost of the service, item, or drug within 60 calendar days after we get your request.
- If you haven't paid for the service, item, or drug yet, we will send the payment directly to your provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service, item, or drug is not covered, or you did not follow all the rules, we will send you a letter telling you that we will not pay for the service, item, or drug, and explaining why.

What if the plan or your IDT says the plan will not pay?

If you do not agree with the plan or your IDT's decision, **you can make an appeal**. Follow the appeals process described in Section E3. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service, item, or drug you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal, we will automatically send your case to the OAH. We will notify you by letter if this happens.

- If the OAH reverses the decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the OAH says **No** to your appeal, it means they agree with the decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") You may appeal this decision to the MAC, as described in Section I.

F. Medicare Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your coverage as a Participant of our plan includes many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with an **ADD Drug symbol**. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with **an ADD Drug symbol** follow the process in **Section E**.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask PHP Care Complete FIDA-IDD Plan or your IDT to make about your Part D drugs:

- You ask the plan or your IDT to make an exception such as:
  - Asking the plan or your IDT to cover a Part D drug that is not on our Drug List.
  - Asking the plan or your IDT to waive a restriction on our coverage for a drug (such as limits on the amount of the drug you can get).
- You ask the plan or your IDT if a drug is covered for you (for example, when your drug is on our Drug List but we require you to get approval before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining who to contact for a coverage decision.

- You ask the plan or your IDT to decide that the plan must pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> The **legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision made by the plan or your IDT, you can appeal. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2**. Also refer to Sections F3 and F4.	Skip ahead to **Section F4**	Skip ahead to **Section F4**	Skip ahead to **Section F5**

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask the plan or your IDT to make an "exception."

When you ask for an exception, your prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your prescriber can ask the plan or your IDT to make:

1. Covering a Part D drug that is not on our Drug List.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5 for more information).
    - The extra rules and restrictions on coverage for certain drugs include:

- Being required to use the generic version of a drug instead of the brand name drug.
- Getting approval before the plan will cover the drug for you. (This is sometimes called PA.)

Being required to try a different drug first before the plan will cover the drug you are for. (This is sometimes called "step therapy.")

Quantity limits. For some drugs, the plan limits the amount of the drug you can have.

> The **legal term** for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

F3. Important things to know about asking for exceptions

Your prescriber must tell us the medical reasons

Your prescriber must give the plan or your IDT a statement explaining the medical reasons for requesting an exception. The decision about the exception will be faster if you include this information from your prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, the plan or your IDT will generally not approve your request for an exception

PHP Care Complete FIDA-IDD Plan or your IDT will say Yes or No to your request for an exception.

- If the plan or your IDT says **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your provider continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If the plan or your IDT says **No** to your request for an exception, you can ask for a review of the decision by making an appeal. Section F5 tells how to make an appeal.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax your Care Manager or Participant Services to make your request. You, your representative, or prescriber can do this. You can call Participant Services at 1-855-747-5483. You can call your Care Manager at the phone number listed on the back of your ID Card. Include your name, contact information, and information about the claim.
- You, your prescriber, or your representative can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D to find out how to give permission to someone else to act as your representative.
- You do not need to give your prescriber written permission to ask for a coverage decision on your behalf.
- If you want to ask the plan to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for the cost of a drug you have paid for.
- If you are asking for an exception, provide the "supporting statement." Your prescriber must give the plan or your IDT the medical reasons for the drug exception. We call this the "supporting statement."
- Your prescriber can fax or mail the statement to us. Or your prescriber can speak with us on the phone, and then fax or mail a statement.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax your Care Manager or Participant Services. Or ask your representative or prescriber to ask for a coverage decision for you. You will get an answer on a standard coverage decision within 72 hours. You will get an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your prescriber.
- You or your prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask for a "fast coverage decision"

The "standard deadlines" will apply unless the plan or your IDT have agreed to use the "fast deadlines."

- A **standard coverage decision** means the plan or your IDT will give you an answer within 72 hours after your prescriber's statement is received.
- A **fast coverage decision** means the plan or your IDT will give you an answer within 24 hours after your prescriber's statement is received.

> The **legal term** for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function**.

If your prescriber says that your health requires a "fast coverage decision," the plan or your IDT will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your prescriber's support), the plan or your IDT will decide whether you get a fast coverage decision.
- If the plan or your IDT decides that your medical condition does not meet the requirements for a fast coverage decision, the standard deadline will be used instead. You will get a letter telling you that. The letter will tell you how to file a grievance about the decision to give you a standard decision. You can file a "fast grievance" and get a response to your grievance within 24 hours. For more information about the process for filing grievances, including fast grievances, refer to Section J.

Deadlines for a "fast coverage decision"

- If the plan or your IDT is using the fast deadlines, you will get an answer within 24 hours. This means within 24 hours after the plan or your IDT gets your request. Or, if you are asking for an exception, this means within 24 hours after the plan or your IDT gets your prescriber's statement supporting your request. You will get an answer sooner if your health requires it.
- If the plan or your IDT does not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity (IRE) will review your request.

- **If the answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after your request is received or your prescriber's supporting statement is received.
- **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If the plan or your IDT is using the standard deadlines, you will get an answer within 72 hours after your request is received. Or, if you are asking for an exception, this means within 72 hours after your prescriber's supporting statement is received. You will get an answer sooner if your health requires it.
- If the plan or your IDT does not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an IRE will review your request.
- **If the answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours of your request or, if you are asking for an exception, your prescriber's supporting statement.
- **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- The plan or your IDT must give you an answer within 14 calendar days after your request is received.
- If the plan or your IDT does not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an IRE will review your request.
- **If the answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days after your request is received.
- **If the answer is No** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-747-5483 and 711 for TTY users .
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice that tells you the decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

At a glance: How to make a Level 1 Appeal

You, your prescriber, or your representative may put your request in writing and mail or fax it to us. *You may also ask for an appeal by calling us.*

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The **legal term** for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision the plan or your IDT made about a drug you have not yet received, you and your prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4.

> The **legal term** for "fast appeal" is **"expedited redetermination."**

Our plan will review your appeal and give you our decision

We take another careful look at all of the information about your coverage request. We check if all the rules were followed when the plan or your IDT said **No** to your request. We may contact you or your prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an IRE will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an IRE will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get

your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.

- If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the IRE will review our decision.

At a glance: How to make a Level 2 Appeal

If you want the IRE to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Participant Services at 1-855-747-5483.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with the plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

The **legal term** for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the IRE for a "fast appeal."

- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the IRE must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity (IRE) says No to your Level 2 Appeal?

No means the IRE agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor, IDT, and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor, IDT, or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. There is a special, faster process for appealing hospital discharge decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section E on page <xx>. However, both options

are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with the plan.

G1. Learning about your Medicare rights

> Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called "An Important Message from Medicare about Your Rights." If you do not get this notice, ask any hospital employee for it. If you need help, please call Participant Services at 1-855-747-5483. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The "Important Message" tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. The call is free.
- You can also find the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI.
- If you need help, please call Participant Services or Medicare at the numbers listed above.

G2. Quality Improvement Organization (QIO) Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. This section tells you how to ask for a Level 1 Appeal with the QIO. The QIO will do a Level 1 Appeal review to check if your planned discharge date is medically appropriate for you.

In New York, the QIO is called Livanta. To make a Level 1 Appeal to change your discharge date, call Livanta at 1-866-815-5440.

Call right away!

Call the QIO **before** you leave the hospital and no later than your planned discharge date. "An Important Message from Medicare about Your Rights" contains information on how to reach the QIO.

- If you call before you leave, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the QIO.
- If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the QIO for your state at **1-866-815-5440** and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

- If you miss the deadline for contacting the QIO about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Participant Services at 1-855-747-5483. You can also call HIICAP at 1-800-701-0501. You may also call ICAN at 1-844-614-8800.

What is a Quality Improvement Organization (QIO)?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the QIO for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The **legal** term for "fast review" is **"immediate review."**

What happens during the fast review?

- The reviewers at the QIO will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your provider, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your provider, the hospital, and we think it is right for you to be discharged on that date.

The **legal term** for this written explanation is called the **"Detailed Notice of Discharge"**. You can get a sample by calling Participant Services at 1-855-747-5483. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1-877-486-2048.) Or you can find a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

What if the answer is Yes?

- If the QIO says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the QIO says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you its answer.
- If the QIO says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the QIO gives you its answer.
- If the QIO turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Quality Improvement Organization (QIO) Level 2 Appeal to change your hospital discharge date

If the QIO has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the QIO again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the QIO said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In New York, the QIO is called Livanta. You can reach Livanta at 1-866-815-5440.

- Reviewers at the QIO will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the QIO reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the QIO for your state at **1-866-815-5440** and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the QIO agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the QIO turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

G4. What happens if you miss an appeal deadline

If you miss the Level 1 appeal deadline with the QIO, you can still file an appeal directly with our plan. Follow the same process described in Section E, which is also summarized below.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the QIO (which is within 60 days or no later than your planned discharge date, whichever comes first), you can file an appeal with our plan. Ask us for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

At a glance: How to make a Level 1 Alternate Appeal

Call our Participant Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your hospital stay. We check if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision as fast as your condition requires but no later than 72 hours after you ask for a "fast review."
- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
    - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the OAH. When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The **legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

If we do not agree with you that your hospital discharge date should be changed, we will send the information for your Level 2 Appeal to the OAH within 2 business days of the Level 1 decision being

reached. If you think we are not meeting this deadline or other deadlines, you can file a grievance. Section J on page XX tells how to file a grievance.

During the Level 2 Appeal, the OAH reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the OAH.

- The OAH does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The OAH is not connected with our plan.
- A Hearing Officer from the OAH will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the OAH says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the OAH says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the OAH will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by the MAC. Section I of this chapter has more information about additional appeal levels.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a SNF.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved CORF. Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

- With any of these three types of care, you have the right to keep getting covered services for as long as your provider or IDT says you need it.
- When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your services.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. There is a special, faster process for appealing these types of coverage decisions. It is handled by the Medicare-designated QIO. It is highly recommended that you use the faster process instead of the regular appeal process described in Section E. However, both options are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with the plan.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your services. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your services and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting services.

When your coverage ends, we will stop paying for your services.

H2. Quality Improvement Organization (QIO) Level 1 Appeal to continue your care

If you think we are ending coverage of your services too soon, you can file an appeal. This section tells you how to ask for a Level 1 Appeal with the QIO.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a grievance. Section J tells you how to file a grievance.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Participant Services at 1-855-747-5483. Or call HIICAP at 1-800-701-0501.

During a Level 1 Appeal, the QIO will review your appeal and decide whether to change the decision we made. In New York, the QIO is called Livanta. You can reach Livanta at **1-866-815-5440**. Information about appealing to the QIO is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the QIO for your state at 1-866-815-5440 and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the QIO no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the QIO about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4.

The **legal term** for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Participant Services at 1-855-747-5483 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or find a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI

What happens during the Quality Improvement Organization's (QIO's) review?

- The reviewers at the QIO will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the QIO explaining why your services should end.

- The reviewers will also look at your medical records, talk with your provider, and review information that the plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> The **legal term** for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, SNF care, or CORF services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Quality Improvement Organization (QIO) Level 2 Appeal to continue your care

If the QIO said **No** to the Level 1 Appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the QIO will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, SNF care, or CORF services after the date when we said your coverage would end.

In New York, the QIO is called Livanta. You can reach Livanta at 1-866-815-5440. Ask for the Level 2 review **within 60 calendar days** after the day when the QIO said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the QIO will take another careful look at all of the information related to your appeal.
- The QIO will make its decision within 14 calendar days of receipt of your appeal request.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the QIO for your state at 1-866-815-5440 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss the Level 1 appeal deadline with the QIO, you can still file an appeal directly with our plan. Follow the same process described in Section E which is also summarized below.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the QIO, you can file an appeal with our plan. Ask us for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

At a glance: How to make a Level 1 Alternate Appeal

Call our Participant Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your home health care, SNF care, or care you are getting at a CORF. We check if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision as quickly as your condition requires but not later than 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the OAH. When we do this, it means that your case is automatically going to Level 2 of the appeals process.

> The **legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to continue your care for longer

If we do not agree with you that your services should continue, we will send the information for your Level 2 Appeal to the OAH within 2 business days of the Level 1 decision being reached. If you think we are not meeting this deadline or other deadlines, you can file a grievance. Section J on page <xx> tells how to file a grievance.

During the Level 2 Appeal, the OAH reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The OAH does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The OAH is not connected with our plan.
- A Hearing Officer from the OAH will take a careful look at all of the information related to your appeal.

At a glance: How to make a Level 2 Alternate Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the OAH.

- If the OAH says **Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- If the OAH says **No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the OAH will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal with the MAC. Section I on page <xx> has more information about additional appeal levels.

I. Taking your appeal beyond Level 2

I1. Next steps for services, items, and drugs (not Medicare Part D drugs)

If you made a Level 1 Appeal and a Level 2 Appeal as described in Sections E, G, or H, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the OAH will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is a review by the MAC. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact ICAN. The phone number is 1-844-614-8800.

I2. Next steps for Medicare Part D drugs

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare Part D drugs as described in Section F, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the IRE will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the drugs you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can use the MAC. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact ICAN. The phone number is 1-844-614-8800.

J. How to file a grievance

J1. What kinds of problems should be grievances

"Filing a grievance" is another way of saying "making a complaint." The grievance process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the grievance process.

Grievances about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Grievances about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Grievances about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- PHP Care Complete FIDA-IDD Plan staff treated you poorly.
- You think you are being pushed out of the plan.

Grievances about accessibility

- You cannot physically access the health care services and facilities in a provider's office.

At a glance: How to file a grievance

You can file an internal grievance with our plan and/or an external grievance with an organization that is not connected to our plan.

To file an internal grievance, call Participant Services or send us a letter.

There are different organizations that handle external grievances. For more information, read Section J3.

- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Grievances about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by providers, pharmacists, or other health professionals or by Participant Services or other plan staff.

Grievances about cleanliness

- You think the clinic, hospital or provider's office is not clean.

Grievances about language access

- Your provider does not provide you with an interpreter during your appointment.

Grievances about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Grievances about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain services.
- You believe we did not forward your case to the OAH or IRE on time.

Are there different types of grievances?

Yes. You may file an internal grievance and/or an external grievance. An internal grievance is filed with and reviewed by our plan. An external grievance is filed with and reviewed by an organization that is not affiliated with our plan. If you need help filing an internal and/or external grievance, you can call ICAN at 1-844-614-8800.

J2. Internal grievances

To file an internal grievance, call Participant Services at 1-855-747-5483 and 711 for TTY users. You can make the grievance at any time unless it is about a Part D drug. If the grievance is about a Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Participant Services will tell you.
- You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing.

> The **legal term** for "fast grievance" is **"expedited grievance."**

We answer most grievances within 30 calendar days. If possible, we will answer you right away. If you call us with a grievance, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- If you need a response faster because of your health, we will give you an answer within 48 hours after we get all necessary information (but no more than 7 calendar days from the receipt of your grievance).
- If you are filing a grievance because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast grievance" and respond to your grievance within 24 hours.
- If you are filing a grievance because we took extra time to make a coverage decision, we will automatically give you a "fast grievance" and respond to your grievance within 24 hours.

If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days to answer your grievance. We will tell you in writing why we need more time.

If we do not agree with some or all of your grievance, we will tell you and give you our reasons. We will respond whether we agree with the grievance or not. If you disagree with our decision, you can file an external grievance.

J3. External grievances

You can tell Medicare about your grievance

You can send your grievance (complaint) to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

Your grievance will be sent to the Medicare and Medicaid team overseeing our plan and the FIDA-IDD Program.

You can tell the New York State Department of Health (NYSDOH) about your grievance

To file a grievance with NYSDOH, call the NYSDOH Helpline at 1-866-712-7197. Your grievance will be sent to the Medicare and Medicaid team overseeing our plan and the FIDA-IDD Program.

You can file a grievance with the Office for Civil Rights

You can file a grievance with the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can file a grievance about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

`New Jersey, New York, Puerto Rico, Virgin Islands
Office for Civil Rights, *New York Office*
U.S. Department of Education
32 Old Slip, 26th Floor
New York, NY 10005-2500
Telephone: 646-428-3800
Fax: 646-428-3843
E-mail: OCR.NewYork@ed.gov

You may also have rights under the Americans with Disability Act and under. You can contact ICAN for assistance. The phone number is 1-844-614-8800.

You can file a grievance with the Quality Improvement Organization (QIO)

When your grievance is about quality of care, you also have two choices:

- If you prefer, you can make your grievance about the quality of care directly to the QIO (without making the grievance to us).
- Or you can make your grievance to us **and** to the QIO. If you make a grievance to this organization, we will work with them to resolve your grievance.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to Chapter 2.

In New York, the QIO is called Livanta. The phone number for Livanta is 1-866-815-5440.

Chapter 10: Ending your participation in our FIDA-IDD Plan

Introduction

This chapter tells about ways you can end your participation in our FIDA-IDD Plan and access your Medicare and Medicaid coverage options after you leave PHP Care Complete FIDA-IDD Plan. If you leave our plan, you will still be in the Medicare and Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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I. How to get more information about ending your participation in our FIDA-IDD Plan 244

A. When you can end your participation in our FIDA-IDD Plan

Your participation will end on the last day of the month that we get your request to leave PHP Care Complete FIDA-IDD Plan. For example, if we get your request on June 25, your coverage with our plan will end on June 31. Your Medicaid and Medicare coverage will begin the first day of the next month (July 1, in this example). If you leave our plan, you can get information about your:

- Medicare options in the table on page 3.
- Medicaid services on page 4.

You can get more information about when you can end your participation by calling:

- New York Medicaid Choice at 1-844-343-2433, Monday through Friday from 8:30 a.m. to 8 p.m. and Saturday from 10 a.m. to 6 p.m. TTY users should call 1-888-329-1541.
- Health Insurance Information, Counseling and Assistance Program (HIICAP at 1-800-701-0501).
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any issues you may have with your FIDA-IDD Plan. To contact ICAN, call 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800).

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5 Section G for information about drug management programs.

B. How to end your participation in our FIDA-IDD Plan

If you decide to end your participation in PHP Care Complete FIDA-IDD Plan, call New York Medicaid Choice or Medicare and tell them you want to leave PHP Care Complete FIDA-IDD Plan:

- Call New York Medicaid Choice at 1-844-343-2433, Monday through Friday from 8:30 a.m. to 8:00 p.m. and Saturday from 10:00 a.m. to 6:00 p.m. TTY users should call 1-888-329-1541; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave PHP Care Complete FIDA-IDD Plan is in the chart on pages 3 & 4.

C. How to get Medicare and Medicaid services separately if you leave our plan

You will return to getting your Medicare and Medicaid services separately as described below.

C1. Ways to get your Medicare services

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

You have three options for getting your Medicare services. By enrolling in one of these options, you will automatically end your participation in PHP Care Complete FIDA-IDD Plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE)	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from PHP Care Complete FIDA-IDD Plan when your new plan's coverage begins.

2. You can change to: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from PHP Care Complete FIDA-IDD Plan 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 have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from PHP Care Complete FIDA-IDD Plan when your Original Medicare coverage begins.

C2. How to get your Medicaid services

If you leave the FIDA-IDD Plan, you will still be able to get your Medicaid services.

- You will get your long-term services and supports and your Medicaid physical and behavioral health services through Medicaid Fee-for-Service.
- You can use any provider that accepts Medicaid.

C. If you were getting services through the OPWDD Comprehensive Waiver before enrolling in the FIDA-IDD Plan

If you were getting services through the OPWDD Comprehensive Waiver before enrolling in the FIDA-IDD Plan, you will continue to get OPWDD waiver services upon your disenrollment from our plan.

Until your participation ends, you will keep getting your medical, behavioral health, OPWDD waivered services (if you are enrolled in the OPWDD Comprehensive Waiver) and drugs through our FIDA-IDD Plan.

As described above, if you choose to leave PHP Care Complete FIDA-IDD Plan, it may take time before your participation ends and your new Medicare and Medicaid coverage begins. During this time, keep getting your prescription drugs, services, and items through our plan.

- Use our network providers to receive medical care.
- **If you are hospitalized on the day that your participation in PHP Care Complete FIDA-IDD Plan ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new coverage begins before you are discharged.

E. Keep getting your medical items, services and drugs through our plan until your membership ends

These are the cases when the FIDA-IDD Program rules require that your participation must end:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid.
- If you permanently move out of our service area.
- If you are away from our service area for more than six consecutive months. If you move or take a long trip, you need to call Participant Services to find out if the place you are moving or traveling to is in PHP Care Complete FIDA-IDD Plan's service area.
- If you go to jail or prison for a criminal offense.

- If you lie about or withhold information about other insurance you have for health care or prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a Participant in our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a Participant on this basis.
    - We must disenroll you if you don't meet this requirement.

In any of the above situations, New York Medicaid Choice will send you a disenrollment notice and will be available to explain your other coverage options.

In addition, we can ask that the FIDA-IDD Program remove you from PHP Care Complete FIDA-IDD Plan for the following reasons:

- If you intentionally give us incorrect information when you are enrolling in PHP Care Complete FIDA-IDD Plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical and other care for you and other Participants of PHP Care Complete FIDA-IDD Plan even after we make and document our efforts to resolve any problems you may have.
- If you knowingly fail to complete and submit any necessary consent or release form allowing PHP Care Complete FIDA-IDD Plan and providers to access health care and service information that is necessary for us to deliver care to you.
- If you let someone else use your Participant ID Card to get medical and other care.
    - If we end your participation because of this reason, Medicare may have your case investigated by the Inspector General.

In any of the above situations, we will notify you of our concern before we ask the FIDA-IDD Program approval to have you disenrolled from PHP Care Complete FIDA-IDD Plan. We will do this so that you have the opportunity to resolve the problems first. If the problems aren't resolved, we will notify you again once we have submitted the request. If the FIDA-IDD Program approves our request, you will get a disenrollment notice. New York Medicaid Choice will be available to explain your other coverage options.

F. Rules against asking you to disenroll from our FIDA-IDD Plan for any health-related reason

If you feel that we are asking that you be disenrolled from PHP Care Complete FIDA-IDD Plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You should also call Medicaid at 1-800-541-2831.

G. Your right to ask for a fair hearing if the FIDA-IDD Program ends your participation in our FIDA-IDD Plan

If the FIDA-IDD Program ends your participation in PHP Care Complete FIDA-IDD Plan, the FIDA-IDD Program must tell you its reasons in writing. It must also explain how you can ask for a fair hearing about the decision to end your participation.

H. Your right to file a grievance with PHP Care Complete FIDA-IDD Plan if we ask the FIDA-IDD Program to end your participation in our FIDA-IDD Plan

If we ask the FIDA-IDD Program to end your participation in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance or make a complaint about our request to end your participation. You can refer to Chapter 9 Section C for information about how to file a grievance.

- **Note:** You can use the grievance process to express your dissatisfaction with our request to end your participation. However, if you want to ask that the decision be changed, you must file a fair hearing as described in Section G just above.

I. How to get more information about ending your participation in our FIDA-IDD Plan

If you have questions or would like more information on when we can end your participation, you can call Participant Services at 1-855-747-5483 and 711 for TTY users, 8AM to 8PM, seven days a week.

ICAN can also give you free information and assistance with any issues you may have with your FIDA-IDD Plan. To contact ICAN, call 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800).

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your participation in PHP Care Complete FIDA-IDD Plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Participant Handbook*.

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B. Notice about nondiscrimination 246

C. Notice about PHP Care Complete FIDA-IDD Plan as a second payer 246

C1. PHP Care Complete FIDA-IDD Plan's Right of Subrogation 246

C2. PHP Care Complete FIDA-IDD Plan's Right of Reimbursement 247

C3. Your responsibilities 247

D. Participant confidentiality and notice about privacy practices 247

E. Notice of action 248

A. Notice about laws

Many laws apply to this *Participant Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation. You also cannot be treated differently because of your gender identity.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users (people who are deaf, hard of hearing, or speech disabled) can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights. Jacob Javits Federal Building, 26 Federal Plaza - Suite 3312, New York, NY 10278.

If you have a disability and need help accessing health care services or a provider, call Participant Services. If you have a complaint, such as a problem with wheelchair access, Participant Services can help.

C. Notice about PHP Care Complete FIDA-IDD Plan as a second payer

Sometimes someone else has to pay first for the services, items, and drugs that we provide. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

PHP Care Complete FIDA-IDD Plan has the right and responsibility to collect payment for covered services, items, and drugs when someone else has to pay first.

C1. PHP Care Complete FIDA-IDD Plan's Right of Subrogation

Subrogation is the process by which PHP Care Complete FIDA-IDD Plan gets back some or all of the costs of your health care from another insurer. Examples of other insurers include:

- Your motor vehicle or homeowner's insurance

- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' Compensation

If an insurer other than PHP Care Complete FIDA-IDD Plan should pay for services, items, or drugs related to an illness or injury, PHP Care Complete FIDA-IDD Plan has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by PHP Care Complete FIDA-IDD Plan will be secondary when another plan, including another insurance plan, provides you with coverage for FIDA-IDD-covered services, items, or drugs.

C2. PHP Care Complete FIDA-IDD Plan's Right of Reimbursement

If you get money from a lawsuit or settlement for an illness or injury, PHP Care Complete FIDA-IDD Plan has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

C3. Your responsibilities

As a Participant of PHP Care Complete FIDA-IDD Plan, you agree to:

- Let us know of any events that may affect PHP Care Complete FIDA-IDD Plan's rights of Subrogation or Reimbursement.
- Cooperate with PHP Care Complete FIDA-IDD Plan when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
- Sign documents to help PHP Care Complete FIDA-IDD Plan with its rights to Subrogation and Reimbursement.
- Authorize PHP Care Complete FIDA-IDD Plan to investigate, ask for and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.

If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

D. Participant confidentiality and notice about privacy practices

We will ensure that all information, records, data, and data elements related to you, used by our organization, employees, subcontractors, and business associates, shall be protected from unauthorized disclosure pursuant to 42 CFR Part 431, Subpart F; 45 CFR Part 160; and 45 CFR Part 164, Subparts A and E.

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, call Participant Services at 1-855-747-5483 and 711 for TTY users.

E. Notice of action

We must use a coverage determination notice to notify you of a denial, termination, and delay or modification in benefits. If you disagree with our decision, you can file an appeal with our plan. You will not have to pay for any of these proceedings. For more information about appeals, refer to Chapter 9.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Participant Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Participant Services.

Activities of daily living (ADLs): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, walking, or brushing their teeth.

Aid to continue: You can continue getting your services or items that are the subject of your appeal while you are waiting for a decision on a Level 1, 2, or 3 Appeal. This continued coverage is called "aid paid pending" or "continuing benefits." All other services and items automatically continue at approved levels during your appeal.

Appeal: A way for you to challenge a coverage decision if you think it is wrong. You can ask us to change a coverage decision by filing an appeal. Chapter 9 Section *D* explains appeals, including how to make an appeal.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar: A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Manager: One main person who works with you, with the FIDA-IDD Plan, with your care providers, and with your Interdisciplinary Team (IDT) to make sure you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid. Chapter 2 Section G explains how to contact CMS.

Comprehensive Assessment or Comprehensive Service Planning Assessment: A review of your medical, behavioral health, Community-based and Facility-based long-term services and supports (LTSS), developmental disability services, and social needs. It is used by you and your Interdisciplinary Team (IDT) to develop your Life Plan. The term refers to the initial comprehensive assessment you will have when you first join PHP Care Complete FIDA-IDD Plan. The comprehensive assessment will be conducted by your Care Manager in your home, which may include the hospital, nursing facility, or any other place you live at the time the assessment occurs.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Comprehensive Re-assessment: A subsequent comprehensive re-assessment you will have at least once annually but more frequently if necessary due to changes in your needs. The comprehensive re-assessments will be conducted by a licensed professional in your home, which may include the hospital, intermediate care facility, or any other place you live at the time the re-assessment occurs.

Continuing benefits: Refer to “aid to continue.”

Coverage decision: A decision made by your IDT, PHP Care Complete FIDA-IDD Plan, or another authorized provider about whether PHP Care Complete FIDA-IDD Plan will cover a service for you. This includes decisions about covered services, items, and drugs. Chapter 9 Section D explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and other drugs covered by PHP Care Complete FIDA-IDD Plan.

Covered services and items: The general term we use to mean all of the health care, LTSS, developmental disability services, supplies, prescription and OTC drugs, equipment, and other services covered by PHP Care Complete FIDA-IDD Plan. Covered services and items are individually listed in Chapter 4 Section D.

Cultural Competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your participation in PHP Care Complete FIDA-IDD Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tier: A group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). Every drug on the *List of Covered Drugs* (Drug List) is in one of 3 tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are 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, and walkers.

Emergency: A medical emergency is when you, or any other person with average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. The plan covers emergency care from out-of-network providers.

Enrollment Broker: The independent entity (New York Medicaid Choice) that handles FIDA-IDD Plan enrollments and disenrollments for the State of New York.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Explanation of Benefits **(EOB):** A summary of the drugs you got during a certain month. It also shows the total payments made by PHP Care Complete FIDA-IDD Plan and Medicare for you since January 1.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drugs costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Fair hearing: A chance for you to tell your problem in New York State court and show that a decision we made about your Medicaid or FIDA-IDD Program eligibility is wrong.

Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Plan: A managed care organization under contract with Medicare and Medicaid to provide eligible individuals with all services available through both programs as well as new services. The plan is made up of doctors, hospitals, developmental disability providers, pharmacies, providers of long-term services,

and other providers. It also has Care Managers to help you manage all your providers and services. They all work together to provide the care you need.

Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) Program: A demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid and who have intellectual and developmental disabilities. Under this demonstration, the State and federal government are testing new ways to improve how you get your Medicare and Medicaid health care services.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

Health Insurance Information, Counseling and Assistance Program (HIICAP): HIICAP is the State Health Insurance Assistance Program for New York. HIICAP gives free health insurance counseling to people with Medicare. HIICAP is not connected with any insurance company, managed care plan, or FIDA-IDD Plan.

Home and Community-Based Services: Services developed by the Office for People With Developmental Disabilities (OPWDD) under home and community-based waivers to meet the needs of individuals with intellectual and/or developmental disabilities (I/DD) who prefer to get long-term care services and supports (LTSS) in their home or community, rather than in an institutional setting.

OPWDD waivered services include day habilitation, live-in caregiver, prevocational employment, supported employment, residential habilitation, respite, fiscal intermediary, individual directed goods and services, support brokerage, assistive technology-adaptive devices, community habilitation, community transition, environmental modifications (home accessibility), vehicle modifications, intensive behavioral supports, and pathways to employment.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

A Participant who has a terminal prognosis has the right to elect hospice.

A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

PHP Care Complete FIDA-IDD Plan must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your PHP Care Complete FIDA-IDD Plan Participant ID Card when you get any services or prescriptions. Call Participant Services if you get any bills you do not understand.

Because PHP Care Complete FIDA-IDD Plan pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Independent Consumer Advocacy Network (ICAN): An office that helps you if you are having problems with PHP Care Complete FIDA-IDD Plan. ICAN's services are free. Refer to Chapter 2 Section I for information about how to contact ICAN.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated Administrative Hearing: A meeting before the Integrated Administrative Hearing Office during which you can explain why you think PHP Care Complete FIDA-IDD Plan or your Interdisciplinary Team (IDT) made the wrong decision.

Integrated Administrative Hearing Office (IAHO): A unit within the New York State Office of Temporary and Disability Assistance that conducts many of the Level 2 Appeals as described in Chapter 9 Section D.

Interdisciplinary Team (IDT): Your IDT will include your Care Manager, your primary provider(s) of developmental disability services, and other health professionals who are there to help you get the care you need. Your IDT will also help you make a Life Plan and coverage decisions.

Life Plan: A plan for what services and items you will get, how you will get them, and your goals of care. Your Life Plan is developed by you and your Interdisciplinary Team (IDT).

List of Covered Drugs **(Drug List):** A list of prescription drugs covered by PHP Care Complete FIDA-IDD Plan. PHP Care Complete FIDA-IDD Plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): LTSS are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS are sometimes also referred to as long-term care, long-term supports and services, or home and community-based services.

Medicaid (or Medical Assistance): A program run by the federal government and the State that helps people with limited incomes and resources pay for health care, long-term services and supports, and medical costs.

It covers extra services and drugs not covered by Medicare.

Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Refer to Chapter 2 Section D for information about how to contact Medicaid in your state.

Medically necessary: Those services and items necessary to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. PHP Care Complete FIDA-IDD Plan will provide coverage in accordance with the more favorable of the current Medicare and New York State Department of Health (NYSDOH) coverage rules, as outlined in NYSDOH and federal rules and coverage guidelines.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (ESRD) (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan.

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (MAC): The entity that conducts Level 3 Appeals, as described in Chapter 9 Section E.

Medicare-covered services and items: Services and items covered by Medicare Part A and Part B. All Medicare health plans, including PHP Care Complete FIDA-IDD Plan, must cover all of the services and items that are covered by Medicare Part A and Part B.

Medicare Part A: The Medicare program that covers most medically necessary hospitals,skilled nursing facility,home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. PHP Care Complete FIDA-IDD Plan includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for PHP Care Complete FIDA-IDD Plan Participants. We call them "network pharmacies" because they have agreed to work with PHP Care Complete FIDA-IDD Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, developmental disability services and long-term services and supports (LTSS).

They are licensed or certified by Medicare and by the State to provide health care services.

We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our Participants an extra amount.

While you are a Participant of PHP Care Complete FIDA-IDD Plan, you must use network providers to get covered services and items, unless under certain conditions such as in cases of an emergency or urgently needed care. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand

what to do. The ombudsman's services are free. The ombudsman for individuals enrolled in the FIDA-IDD Plan is ICAN. You can find more information about ICAN in Chapter 2 Section I and Chapter 9 Section B of this handbook.

Organization determination: PHP Care Complete FIDA-IDD Plan has made an organization determination when it, or one of its providers, makes a decision about whether services and items are covered or how much you have to pay for covered services and items. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 Section D explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the federal government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers in amounts that are set by Congress.

You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).

Original Medicare is available everywhere in the United States.

If you do not want to be in PHP Care Complete FIDA-IDD Plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with PHP Care Complete FIDA-IDD Plan to coordinate or provide covered drugs to Participants of PHP Care Complete FIDA-IDD Plan. Most drugs you get from out -of -network pharmacies are not covered by PHP Care Complete FIDA-IDD Plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by PHP Care Complete FIDA-IDD Plan and is not under contract to provide covered services and items to Participants of PHP Care Complete FIDA-IDD Plan. Chapter 3 Section E explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: OTC drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Participant (Participant of our plan, or plan Participants): A person with Medicare and Medicaid who qualifies to get covered services and items through the FIDA-IDD Program, who has enrolled in PHP Care Complete FIDA-IDD Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the State.

***Participant Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explains your coverage, what we must do, your rights, and what you must do as a Participant of PHP Care Complete FIDA-IDD Plan.

Participant Services: A department within PHP Care Complete FIDA-IDD Plan responsible for answering your questions about your participation, benefits, grievances, and appeals. Refer to Chapter 2 Section A for information about how to contact Participant Services.

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to PHP Care Complete FIDA-IDD Plan's Notice of Privacy Practices for more information about how PHP Care Complete FIDA-IDD Plan protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Primary Care Provider (PCP): Your main doctor or other provider who is responsible for providing many of your preventive and primary care services and items. Your PCP will be a part of your Interdisciplinary Team (IDT).

Your PCP will participate in developing your Life Plan, making coverage determinations about services and items you asked for, and approving authorizations for services and items that will be part of your Life Plan.

Your PCP may be a primary care physician, a nurse practitioner, or a physician assistant.

For more information, refer to Chapter 3 Section E.

Prior authorization (PA): An approval from PHP Care Complete FIDA-IDD Plan you must get before you can get a specific service or drug or use an out-of-network provider. PHP Care Complete FIDA-IDD Plan may not cover the service or drug if you don't get approval.

Some services, items, and drugs are covered only if PHP Care Complete FIDA-IDD Plan, your IDT, or another specific provider authorizes them for you.

Covered services and items that need our plan's PA are marked in the Covered Items and Services Chart in Chapter 4 Section D.

Some drugs are covered only if you get PA from PHP Care Complete FIDA-IDD Plan.

Covered drugs that need PA are marked in the *List of Covered Drugs* (Drug List).

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to Participants. Refer to Chapter 2 Section F for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Service area: A geographic area where a health plan accepts Participants. For a plan that limits which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get PHP Care Complete FIDA-IDD Plan. For more information about the FIDA-IDD Plan's service area, refer to Chapter 1 Section D.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

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

State Medicaid agency: The New York State Medicaid Agency is the New York State Department of Health (NYSDOH), Office of Health Insurance Programs (OHIP).

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

PHP Care Complete FIDA-IDD Plan Participant Services

CALL	1-855-747-5483. Calls to this number are free. 8AM to 8PM, seven days a week Participant Services also has free language interpreter services available for non-English speakers.
TTY	711 for TTY users. Calls to this number are free.
WRITE	• Partners Health Plan • 2500 Halsey Street, Bronx, NY 10461
WEBSITE	*www.phpcares.org*

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(Medicare - Medicaid Plan)

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