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

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

Table of Contents

[A. About “services,” “covered services,” “providers,” and “network providers” 2](#_Toc398649488)

[B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan 2](#_Toc398649489)

[C. Your [care coordinator/care manager (plan’s preference)] 4](#_Toc398649490)

[D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers 4](#_Toc398649491)

[E. How to get behavioral health services 7](#_Toc398649492)

[F. How to get long-term services and supports (LTSS) 7](#_Toc398649493)

[G. How to get transportation services 8](#_Toc398649494)

[H. How to get covered services when you have a medical emergency or urgent need for care 8](#_Toc398649495)

[I. What if you are billed directly for the full cost of services covered by our plan? 10](#_Toc398649496)

[J. How are your health care services covered when you are in a clinical research study? 11](#_Toc398649497)

[K. How are your health care services covered when you are in a religious non-medical health care institution? 12](#_Toc398649498)

[L. Rules for owning durable medical equipment 13](#_Toc398649499)

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

**Services** are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

**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 health care services, medical equipment, and long-term services and supports.

**Network providers** are providers who work with the health plan**.** These providers have agreed to accept our payment [insert if plan has cost sharing: and your cost sharing amount] as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay [insert as applicable: nothing **or** only your share of the cost] for covered services.

# Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

<Plan name> covers all services covered by Medicare and Healthy Connections Medicaid. This includes behavioral health, long term care and prescription drugs.

<Plan name> will generally pay for the health care and services you get if you follow the plan rules. To be covered:

* The care you get must be a **plan benefit.** This means that it must be included in the plan’s Benefits Chart. (The chart is in Chapter 4 [plans may insert reference, as applicable] of this handbook).
* The care must be **medically necessary.** *Medically necessary* means that the services are reasonable and necessary:
* For the diagnosis or treatment of your illness or injury; ***or***
* To improve the functioning of a malformed body member; ***or***
* Otherwise medically necessary under Medicare law.

In accordance with Healthy Connections Medicaid law and regulation, services must be:

* Essential to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity; ***and***
* Provided at an appropriate facility at the appropriate level of care for the treatment of your medical condition; ***and***
* Provided in accordance with generally accepted standards of medical practice.
* [Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.] You must have a network **primary care** **provider (PCP)** who has ordered the care or has told you to see another doctor**.** As a plan member, you must choose a network provider to be your PCP.
* In most cases, [insert as applicable: your network PCP **or** our plan] must give you approval before you can use other providers in the plan’s network. This is called a **referral**. To learn more about referrals, see page <page number>.
* You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman’s health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page <page number>.

To learn more about choosing a PCP, see page <page number>.

* **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
* The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page <page number>.
* If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. [Plans may specify whether authorization should be obtained from the plan prior to seeking care.] In this situation, we will cover the care [insert as applicable: as if you got it from a network provider **or** at no cost to you]. To learn about getting approval to see an out-of-network provider, see page<page number>.
* The plan covers kidney dialysis services when you are outside the plan’s service area for a short time. You can get these services at a Medicare-certified dialysis facility.
* When you first join the plan, you can continue seeing the providers you see now for 180 days or until we have completed your comprehensive assessment and created a transition plan that you agree with. If you need to continue seeing your out-of-network providers after your first 180 days in our plan, we will only cover that care if the provider enters a single case agreement with us. If you are getting ongoing treatment from an out-of-network provider and think they may need a single case agreement in order to keep treating you, contact [Plans must enter name of department or entity] at <phone number>.

# Your [care coordinator/care manager (plan’s preference)]

[Plans should provide applicable information about care coordination, including answers to the following questions.

* What is a [care coordinator/care manager (plan’s preference)]?
* How can a member contact his or her [care coordinator/care manager (plan’s preference)]?

How can a member change his or her [care coordinator/care manager (plan’s preference)]?]

# Getting care from primary care providers, specialists, other network providers, and out-of-network providers

## Getting care from a primary care provider

[**Note:** Insert this section only if your plan uses PCPs.]

You [insert as applicable: may **or** must] choose a primary care provider(PCP) to provide and manage your care.

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

[Plans should describe the following in the context of their plans:

* What is a PCP?
* What types of providers may act as a PCP? [If a State allows specialists to act as a PCP, plans must inform beneficiaries of this and under what circumstances a specialist may be a PCP.]
* Explain the role of a PCP
* What is the role of the PCP in coordinating covered services?
* What is the role of the PCP in making decisions about or obtaining prior authorization, if applicable?]

Can a clinic be my primary care provider? (RHC/FQHC)]

### 

### How do you choose your PCP?

[Plans must describe how to choose a PCP.]

### Changing your PCP

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network. We can help you find a new PCP.

[Plans should describe how to change a PCP and indicate when that change will take effect   
(e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).]

***Services you can get without first getting approval from your PCP***

[**Note:** Insert this section only if plans use PCPs or require referrals to network providers.]

In most cases, you will need approval from your PCP before seeing other providers. This approval is called a **referral.** You can get services like the ones listed below without first getting approval from your PCP:

* Emergency services from network providers or out-of-network providers.
* Urgently needed care from network providers.
* Urgently needed care from out-of-network providers when you can’t get to network providers (for example, when you are outside the plan’s service area).
* Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan’s service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
* Flu shots [insert if applicable: hepatitis B vaccinations, and pneumonia vaccinations] [insert if applicable: as long as you get them from a network provider].
* Routine women’s health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams [insert if applicable: as long as you get them from a network provider].
* Additionally, if you are eligible to receive services from Indian health providers, you may see these providers without a referral.

[Plans should add additional bullets as appropriate.]

## How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

* *Oncologists* care for patients with cancer.
* *Cardiologists* care for patients with heart problems.

*Orthopedists* care for patients with bone, joint, or muscle problems.

[Plans should describe how members access specialists and other network providers, including:

* What is the role (if any) of the PCP in referring members to specialists and other providers?
* What is the process for getting prior authorization? Explain that prior authorization means that the member must get approval from the plan before getting a specific service or drug. Include information about who makes the prior authorization decision (e.g., the plan, the PCP, or another entity) and who is responsible for getting the prior authorization (e.g., the PCP, the member). Refer members to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable] for information about which services require prior authorization.

Does the selection of a PCP result in being limited to specific specialists or hospitals to which that PCP refers (i.e., subnetworks or referral circles)?]

## What if a network provider leaves our plan?

[Plans may edit this section if they are obligated under Healthy Connections Medicaid programs to have a transition benefit when a doctor leaves the plan.]

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

* Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
* When possible, we will give you at least 30 days’ notice so that you have time to select a new provider.
* We will help you select a new qualified provider to continue managing your health care needs.
* If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
* If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

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

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

[HMO plans that are **not** HMOPOS, tell members under what circumstances they may obtain services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Healthy Connections Medicaid out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.]

* **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Healthy Connections Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Healthy Connections Medicaid. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

# How to get behavioral health services

[Plans should provide applicable information about getting behavioral health services.]

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

Long-term services and supports (LTSS) help meet your daily needs for assistance and help improve the quality of your life. LTSS can help you with everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Most of these services are provided in your home or in your community, but they could also be provided in a nursing home or hospital.

LTSS are available to members who are on certain waiver programs operated by the Community Long Term Care (CLTC) division of Healthy Connections Medicaid. Those waivers are:

* Community Choices waiver
* HIV/AIDS waiver
* Mechanical Ventilator Dependent waiver

Members on different waivers can get different kinds and amounts of LTSS. If you think you need LTSS, you can talk to your [care coordinator/care manager (plan’s preference)] about how to access them and whether you can join one of these waivers. Your [care coordinator/care manager (plan’s preference)] can give you information about how to apply for an appropriate waiver, and all of the resources available to you under the plan.

See the Provider and Pharmacy Directory for more information about these programs.

[Plans should provide applicable information about getting LTSS if a member is not a waiver participant.]

## How to get self-directed care

[Plans should provide applicable information about getting self-directed care. This description should include:

* What is self-directed care?
* Who can receive self-directed care? (if limited to waiver populations)

How to get help in employing personal care providers (if applicable)]

# How to get transportation services

[Plans should provide applicable information about getting transportation services.]

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

## Getting care when you have a medical emergency

### What is a medical emergency?

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

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

### What should you do if you have a medical emergency?

If you have a medical emergency:

* **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
* [Plans add if applicable: **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else [plans may replace “someone else” with “your [care coordinator*/care manager (plan’s preference)]*” or other applicable term] should call to tell us about your emergency care, usually within 48 hours.] [Plans must either provide the phone number and days and hours of operation or explain where to find the number (e.g., on the back the plan member card).]

### What is covered if you have a medical emergency?

[Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.]

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4 [plans may insert reference, as applicable].

[Plans that offer a supplemental benefit covering emergencies or ambulance services outside of the country, mention the benefit here and then refer members to Chapter 4 [plans may insert reference, as applicable] for more information.]

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

[Plans may modify this paragraph as needed to address the post-stabilization care for your plan.] After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. 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.

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

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

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

* you go to a network provider, ***or***

the additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (See the next section.)

## Getting urgently needed care

### What is urgently needed care?

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

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

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

* you get this care from a network provider, ***and***

you follow the other rules described in this chapter.

However, if you can’t get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

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

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

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

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

[Plans with overseas care covered as a supplemental benefit, modify this section.]

# What if you are billed directly for the full cost of services covered by our plan?

[Plans may add language to reflect that the organization is not allowed to reimburse members for Healthy Connections Medicaid-covered benefits.]

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay [plans with cost sharing, insert: our share of] the bill.

* You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

[Insert as applicable: If you have paid for your covered services, **or** If you have paid more than your share for covered services,] or if you have gotten a bill for [plans with cost sharing, insert: the full cost of] covered medical services, see Chapter 7 [plans may insert reference, as applicable] to learn what to do.

## What should you do if services are not covered by our plan?

<Plan name> covers all services:

* that are medically necessary, ***and***
* that are listed in the plan’s Benefits Chart (see Chapter 4 [plans may insert reference, as applicable])*,* ***and***

that you get by following plan rules.

* If you get services that aren’t covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

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

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

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

## What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare [plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan] approves the study. If you are part of a study that Medicare [plans that conduct or cover clinical trials that are not approved by Medicare, insert: or our plan]has *not* approved, **you will have to pay any costs for being in the study**.

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

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

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

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

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

If you plan to be in a clinical research study, you or your [care coordinator/care manager (plan’s preference)] should contact Member Services.

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

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.

Medicare pays most of the cost of the covered services you get as part of the study. [Health plans, modify the rest of this paragraph to comply with Healthy Connections Medicaid requirements.] After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

## Learning more

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

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

## What is a religious non-medical health care institution?

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

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

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

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

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

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

* The facility providing the care must be certified by Medicare.
* Our plan’s coverage of services is limited to *non-religious* aspects of care.
* Our plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.
* If you get services from this institution that are provided to you in a facility, the following applies:
* You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
* [Omit this bullet if not applicable] You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

[Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4 [plans may insert reference, as applicable]) or whether there is unlimited coverage for this benefit.]

# Rules for owning durable medical equipment

**Will you own your durable medical equipment?**

[Plans that furnish ownership of certain DME items must modify this section to explain the conditions under which and when specified DME can be owned by the member. Plans should modify this section as necessary to explain their coverage of DME and how to contact the [care coordinator/care manager (plan’s preference)] if they have any questions.

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

You will always own certain items, such as prosthetics. In this section, we discuss durable medical equipment you must rent.

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

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

## What happens if you switch to Medicare?

You will have to make 13 payments in a row under Original Medicare to own the equipment if:

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

you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

* There are no exceptions to this case when you return to Original Medicare.