

## MetroPlus Covered Benefits by Line of Business (LOB)\*

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: AUDIOLOGY, HEARING AID SERVICES &amp; PRODUCTS</b>					
Audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations as medically indicated.	Audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations as medically indicated.	Hearing examination to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist. One (1) hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered.	Audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations as medically indicated.	Audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations as medically indicated.	Audiometric examinations and testing, hearing aid evaluations and hearing aid prescriptions or recommendations as medically indicated.
Hearing Aid Services including selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluations and hearing aid repairs.	Hearing Aid Services including selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluations and hearing aid repairs.	Hearing Aid Services including selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluations and hearing aid repairs.	Hearing Aid Services including selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluations and hearing aid repairs.	Hearing Aid Services including selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluations and hearing aid repairs.	Hearing Aid Services including selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing of hearing aids, conformity evaluations and hearing aid repairs.
Hearing Aid Products are Durable Medical Equipment (DME) and include hearing aids, earmolds, special fittings and replacement parts.	Hearing Aid Products are Durable Medical Equipment (DME) and include hearing aids, earmolds, special fittings and replacement parts.	Hearing aids, including batteries, and repairs, are covered. If medically necessary, more than one (1) hearing aid will be covered.	Hearing Aid Products are Durable Medical Equipment (DME) and include hearing aids, earmolds, special fittings and replacement parts.	Hearing Aid Products are Durable Medical Equipment (DME) and include hearing aids, earmolds, special fittings and replacement parts.	Hearing Aid Products are Durable Medical Equipment (DME) and include hearing aids, earmolds, special fittings and replacement parts.
LIMITATION: None	LIMITATION: None	LIMITATION: One (1) hearing examination per calendar year is covered, unless medically necessary.	LIMITATION: None	LIMITATION: None	LIMITATION: Hearing aids, limited to one (1) per year, with replacement of accessories, repairs and batteries.
EXCLUSION: Batteries are covered as part of the prescription benefit (i.e. Medicaid Fee For Service).	EXCLUSION: Batteries are covered as part of the prescription benefit (i.e. Medicaid Fee For Service).	EXCLUSION: No exclusions but batteries are covered as part of the DME or pharmacy benefit.	EXCLUSION: No exclusions but batteries are covered as part of the DME or pharmacy benefit.	EXCLUSION: Batteries are covered as part of the prescription benefit (i.e. Medicaid Fee For Service).	EXCLUSION: None
AUTHORIZATION: No authorization for exams. Hearing aids are DME and require authorization by MetroPlus Utilization Management.	AUTHORIZATION: No authorization for exams. Hearing aids are DME and require authorization by MetroPlus Utilization Management.	AUTHORIZATION: No authorization for exams. Hearing aids are DME and require authorization by MetroPlus Utilization Management.	AUTHORIZATION: No authorization for exams. Hearing aids are DME and require authorization by MetroPlus Utilization Management.	AUTHORIZATION: No authorization for exams. Hearing aids are DME and require authorization by MetroPlus Utilization Management.	AUTHORIZATION: No authorization for exams. Hearing aids are DME and require authorization by MetroPlus Utilization Management.

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Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES A.1. Inpatient Detoxification Services**

Inpatient detox services are covered.      Inpatient detox services are covered.      Inpatient detox services are covered.      Inpatient detox services are covered.      Inpatient detox services are covered.      Inpatient detox services are covered.

<p>Specific services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Medical management</li> <li>- Bio-psychosocial assessments</li> <li>- Stabilization of medical psychiatric/psychological problems</li> <li>- Individual and group counseling</li> <li>- Level of care determinations</li> <li>- Referral and linkages to other services as necessary</li> </ul>	<p>Specific services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Medical management</li> <li>- Bio-psychosocial assessments</li> <li>- Stabilization of medical psychiatric/psychological problems</li> <li>- Individual and group counseling</li> <li>- Level of care determinations</li> <li>- Referral and linkages to other services as necessary</li> </ul>	<p>Specific services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Medical management</li> <li>- Bio-psychosocial assessments</li> <li>- Stabilization of medical psychiatric/psychological problems</li> <li>- Individual and group counseling</li> <li>- Level of care determinations</li> <li>- Referral and linkages to other services as necessary</li> </ul>	<p>Specific services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Medical management</li> <li>- Bio-psychosocial assessments</li> <li>- Stabilization of medical psychiatric/psychological problems</li> <li>- Individual and group counseling</li> <li>- Level of care determinations</li> <li>- Referral and linkages to other services as necessary</li> </ul>	<p>Specific services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Medical management</li> <li>- Bio-psychosocial assessments</li> <li>- Stabilization of medical psychiatric/psychological problems</li> <li>- Individual and group counseling</li> <li>- Level of care determinations</li> <li>- Referral and linkages to other services as necessary</li> </ul>	<p>Specific services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Medical management</li> <li>- Bio-psychosocial assessments</li> <li>- Stabilization of medical psychiatric/psychological problems</li> <li>- Individual and group counseling</li> <li>- Level of care determinations</li> <li>- Referral and linkages to other services as necessary</li> </ul>
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LIMITATION: Not to exceed five (5) days per visit.

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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES A.2. Inpatient Substance Abuse Rehabilitation Services**

Specific services can include, but are not limited to:

- Comprehensive admission evaluation and treatment planning
- Individual, group and family counseling
- Awareness and relapse prevention
- Education about self-help groups
- Assessment and referral services
- Vocational and educational assessment
- Medical and psychiatric consultation
- Food and Housing
- HIV/AIDS education

Rehabilitation services not covered. Detox services are covered (see A.1).

Note: For SSI members in the HIV SNP, the SNP provides all mental health and substance abuse services.

Substance abuse rehabilitation services are covered when provided in a general hospital or a facility that is operated by the Office of Mental Health.

Detox services are covered (see A.1).

Specific services can include, but are not limited to:

- Comprehensive admission evaluation and treatment planning
- Individual, group and family counseling
- Awareness and relapse prevention
- Education about self-help groups
- Assessment and referral services
- Vocational and educational assessment
- Medical and psychiatric consultation
- Food and Housing
- HIV/AIDS education

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- Comprehensive admission evaluation and treatment planning
- Individual, group and family counseling
- Awareness and relapse prevention
- Education about self-help groups
- Assessment and referral services
- Vocational and educational assessment
- Medical and psychiatric consultation
- Food and Housing
- HIV/AIDS education

Note: For SSI members in the SNP, the SNP provides all mental health and substance abuse services.

Substance abuse rehabilitation services are covered when prescribed by a Plan Provider of an appropriate specialty and provided in a general hospital or a facility that is operated by the Office of Mental Health. Rehabilitation service is therapy that results in significant clinical improvement in a reasonable period of time (not to exceed 30 days per calendar year). Maintenance therapy for chronic conditions is not a covered benefit.

Detox services are covered (see A.1).

These services can be provided in a hospital or freestanding facility.

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**LIMITATION:** Maintenance therapy for chronic conditions does not result in significant clinical improvement and is not a covered benefit.

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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES A.3. Inpatient Behavioral Health Services**

All medically necessary inpatient mental health services, including voluntary and involuntary admissions for mental health services, are covered.

Not Covered. Note: These services are covered under Medicaid Fee For Service.  
  
Note: For SSI members in the SNP, the SNP provides all mental health and substance abuse services.

All medically necessary inpatient mental health services, including voluntary and involuntary admissions for mental health services, are covered.

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Note: For SSI members in the SNP, the SNP provides all mental health and substance abuse services.

All medically necessary inpatient mental health services, including voluntary and involuntary admissions for mental health services, are covered.

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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES B.1. Outpatient Detox Services**

These programs offer treatment for moderate withdrawal on an outpatient basis.

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These programs offer treatment for moderate withdrawal on an outpatient basis.

- Services include, but are not limited to:
- Medical supervision of intoxication and withdrawal conditions
  - Bio-psychosocial assessments
  - Individual and group counseling
  - Level of care determinations
  - Discharge planning
  - Referrals to appropriate services

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- Medical supervision of intoxication and withdrawal conditions
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- Medical supervision of intoxication and withdrawal conditions
  - Bio-psychosocial assessments
  - Individual and group counseling
  - Level of care determinations
  - Discharge planning
  - Referrals to appropriate services

Note: For SSI members in the SNP, the SNP provides all mental health and substance abuse services.

- Services include, but are not limited to:
- Medical supervision of intoxication and withdrawal conditions
  - Bio-psychosocial assessments
  - Individual and group counseling
  - Level of care determinations
  - Discharge planning
  - Referrals to appropriate services

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Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES B.2. Outpatient Behavioral Health Services**

<p>Enrollees must be allowed to self-refer for one (1) mental health assessment from a MetroPlus' participating provider per calendar year. In the case of children, such referrals may originate at the request of a school guidance counselor or similar source.</p>	<p>Not covered.</p> <p>Note: For SSI members in the SNP, the SNP provides all mental health and substance abuse services.</p>	<p>Enrollees must be allowed to self-refer for one (1) mental health assessment from a MetroPlus' participating provider per calendar year. In the case of children, such referrals may originate at the request of a school guidance counselor or similar source.</p>	<p>Enrollees must be allowed to self-refer for one (1) mental health assessment from a MetroPlus' participating provider per calendar year. In the case of children, such referrals may originate at the request of a school guidance counselor or similar source.</p>	<p>Enrollees must be allowed to self-refer for one (1) mental health assessment from a MetroPlus' participating provider in a twelve (12) month period. In the case of children, such referrals may originate at the request of a school guidance counselor or similar source.</p>	<p>Coverage is provided for Professional Services required for crisis intervention and short-term evaluative services when authorized by MetroPlus Utilization Management.</p>
<p>All medically necessary outpatient mental health services are covered and include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>- Assessment</li> <li>- Stabilization</li> <li>- Treatment Planning</li> <li>- Discharge Planning</li> <li>- Verbal therapies</li> <li>- Education</li> <li>- Symptom Management</li> <li>- Case Management Services</li> <li>- Crisis Intervention &amp; Outreach Services</li> <li>- Clozapine Monitoring</li> <li>- Collateral Services as Certified by OMH</li> <li>- Screening, Brief Intervention and Referral to Treatment (SBIRT) for Chemical Dependence</li> </ul>	<p>All medically necessary outpatient mental health services are covered and include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>- Assessment</li> <li>- Stabilization</li> <li>- Treatment Planning</li> <li>- Discharge Planning</li> <li>- Verbal therapies</li> <li>- Education</li> <li>- Symptom Management</li> <li>- Case Management Services</li> <li>- Crisis Intervention &amp; Outreach Services</li> <li>- Clozapine Monitoring</li> <li>- Collateral Services as Certified by OMH</li> </ul>	<p>All medically necessary outpatient mental health services are covered and include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>- Assessment</li> <li>- Stabilization</li> <li>- Treatment Planning</li> <li>- Discharge Planning</li> <li>- Verbal therapies</li> <li>- Education</li> <li>- Symptom Management</li> <li>- Case Management Services</li> <li>- Crisis Intervention &amp; Outreach Services</li> <li>- Clozapine Monitoring</li> <li>- Collateral Services as Certified by OMH</li> <li>- Screening, Brief Intervention and Referral to Treatment (SBIRT) for Chemical Dependence</li> </ul>	<p>All medically necessary outpatient mental health services are covered and include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>- Assessment</li> <li>- Stabilization</li> <li>- Treatment Planning</li> <li>- Discharge Planning</li> <li>- Verbal therapies</li> <li>- Education</li> <li>- Symptom Management</li> <li>- Case Management Services</li> <li>- Crisis Intervention &amp; Outreach Services</li> <li>- Clozapine Monitoring</li> <li>- Collateral Services as Certified by OMH</li> <li>- Screening, Brief Intervention and Referral to Treatment (SBIRT) for Chemical Dependence</li> </ul> <p>Note: For SSI members in the SNP, the SNP provides all mental health and substance abuse services.</p>	<p>All medically necessary outpatient mental health services are covered and include but are not limited to the following:</p> <ul style="list-style-type: none"> <li>- Assessment</li> <li>- Stabilization</li> <li>- Treatment Planning</li> <li>- Discharge Planning</li> <li>- Verbal therapies</li> <li>- Education</li> <li>- Symptom Management</li> <li>- Case Management Services</li> <li>- Crisis Intervention &amp; Outreach Services</li> <li>- Clozapine Monitoring</li> <li>- Collateral Services as Certified by OMH</li> <li>- Screening, Brief Intervention and Referral to Treatment (SBIRT) for Chemical Dependence</li> </ul>	
<p>Services may be provided in-home, office or the community.</p>	<p>Services may be provided in-home, office or the community.</p>	<p>Services may be provided in-home, office or the community.</p>	<p>Services may be provided in-home, office or the community.</p>	<p>Services may be provided in-home, office or the community.</p>	<p>Services may be provided in-home, office or the community.</p>
<p>LIMITATION: Authorization by MetroPlus Utilization Management required for more than 60 outpatient visits per calendar year.</p>	<p>LIMITATION: Not covered</p>	<p>LIMITATION: None</p>	<p>LIMITATION: Limit of 60 outpatient visits per calendar year.</p>	<p>LIMITATION: Authorization by MetroPlus Utilization Management required for more than 60 outpatient visits per calendar year.</p>	<p>LIMITATION: Long term outpatient mental health services are not covered.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care

Medicaid Managed Care w/SSI

Child Health Plus

Family Health Plus

HIV Special Needs Plan

MetroPlus Gold

**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES B.2. Outpatient Behavioral Health Services (continued)**

EXCLUSION: The services listed below are considered "carved out" or "special care services" and may be covered by Medicaid Fee For Service:

- Intensive Psychiatric Rehabilitation Treatment Programs certified by OMH 14 NYCRR Part 587.
- Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Continuing Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Home & Community Based Services Waiver for Seriously Emotionally Disturbed Children.
- Intensive Case Management
- Partial Hospitalization
- Services provided through OMH Designed Clinics for Children with Serious Emotional Disturbance.

EXCLUSION: The following services are not covered:

- Intensive Psychiatric Rehabilitation Treatment Programs certified by OMH 14 NYCRR Part 587.
- Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Continuing Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Home & Community Based Services Waiver for Seriously Emotionally Disturbed Children.
- Intensive Case Management
- Partial Hospitalization
- Services provided through OMH Designed Clinics for Children with Serious Emotional Disturbance.

EXCLUSION: The following services are not covered:

- Intensive Psychiatric Rehabilitation Treatment Programs certified by OMH 14 NYCRR Part 587.
- Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Continuing Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Home & Community Based Services Waiver for Seriously Emotionally Disturbed Children.
- Intensive Case Management
- Partial Hospitalization
- Services provided through OMH Designed Clinics for Children with Serious Emotional Disturbance.

EXCLUSION: The services listed below are considered "carved out" or "special care services" and may be covered by Medicaid Fee For Service:

- Intensive Psychiatric Rehabilitation Treatment Programs certified by OMH 14 NYCRR Part 587.
- Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Continuing Day Treatment Programs certified by OMH 14 NYCRR Part 587.
- Home & Community Based Services Waiver for Seriously Emotionally Disturbed Children.
- Intensive Case Management
- Partial Hospitalization
- Services provided through OMH Designated Clinics for Children with Serious Emotional Disturbance.

EXCLUSION: The following services are not covered:

- Long term mental health and psychiatric treatment, services or treatment for mental retardation or chronic mental illness, the monitoring of medications prescribed for treatment of such conditions, or enrollment in special schools.
- Marriage Counseling
- Family Therapy
- Personal growth and/or educational requirements in conjunction with the mental health and substance abuse benefits.

AUTHORIZATION: Only after 60 outpatient visits per calendar year. MetroPlus Utilization Management monitors visit frequency.

AUTHORIZATION: None

AUTHORIZATION: None

AUTHORIZATION: Only after 60 outpatient visits per calendar year. MetroPlus Utilization Management monitors visit frequency.

AUTHORIZATION: None

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Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES B.3. Chemical Dependence Assessment Self-Referral**

Enrollees must be allowed to self refer for one (1) assessment from a MetroPlus' participating provider per calendar year.

Enrollees must be allowed to self refer for one (1) assessment from a MetroPlus' participating provider per calendar year.

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Enrollees must be allowed to self refer for one (1) assessment from a MetroPlus' participating provider per calendar year.

LIMITATION: None

LIMITATION: Rehab is not covered.

LIMITATION: None

LIMITATION: None

LIMITATION: None

LIMITATION: None

EXCLUSION: - Methadone maintenance treatment programs  
 - Outpatient substance abuse programs, Alcohol Outpatient Clinics, Medically supervised ambulatory chemical dependence outpatient programs  
 - Outpatient Chemical dependence for youth programs  
 - Outpatient alcoholism rehabilitation or chemical dependence outpatient rehabilitation programs  
 - Medically supervised inpatient and outpatient withdrawal services and chemical dependence inpatient rehabilitation and treatment services are covered by Medicaid Fee For Service when these services are ordered by the LDSS under the Welfare Reform.

EXCLUSION: All other Chemical Dependence Services, including Chemical Dependence Inpatient Rehabilitation and Treatment, are covered by Medicaid Fee For Service.

EXCLUSION: Methadone maintenance treatment programs.

EXCLUSION: - Methadone maintenance treatment programs  
 - Outpatient substance abuse programs, Alcohol Outpatient Clinics, Medically supervised ambulatory chemical dependence outpatient programs  
 - Outpatient Chemical dependence for youth programs  
 - Outpatient alcoholism rehabilitation or chemical dependence outpatient rehabilitation programs  
 - Medically supervised inpatient and outpatient withdrawal services and chemical dependence inpatient rehabilitation and treatment services are covered by Medicaid Fee For Service when these services are ordered by the LDSS under Welfare Reform.

AUTHORIZATION: None

AUTHORIZATION: None

AUTHORIZATION: None

AUTHORIZATION: None

AUTHORIZATION: None

AUTHORIZATION: None

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**BENEFIT: BEHAVIORAL/MENTAL HEALTH & SUBSTANCE ABUSE SERVICES B.4. Outpatient Alcohol and Substance Abuse Rehabilitation Services**

Coverage is provided for professional services for outpatient alcohol and substance abuse including diagnostic evaluations to determine the nature and extent of a member's illness, counseling and active therapy. Coverage is not provided for outpatient services that consist primarily of participation in programs of a social, recreational or companionship nature.

LIMITATION: Alcohol and substance abuse rehabilitation service is therapy that is anticipated to result in significant clinical improvement within a reasonable period of time (not to exceed thirty (30) days per calendar year.

EXCLUSION: Maintenance therapy for chronic conditions is not a covered benefit. Coverage is not provided for outpatient services that consist primarily of participation in programs of a social, recreational or companionship nature.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: CHEMOTHERAPY</b>					
<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) are covered. These therapies are covered in inpatient, outpatient and home settings and must be medically necessary and under the supervision or referral of a licensed physician.</p>	<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) are covered. These therapies are covered in inpatient, outpatient and home settings and must be medically necessary and under the supervision or referral of a licensed physician.</p>	<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) are covered. These therapies are covered in inpatient, outpatient and home settings and must be medically necessary and under the supervision or referral of a licensed physician.</p>	<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) are covered. These therapies are covered in inpatient, outpatient and home settings and must be medically necessary and under the supervision or referral of a licensed physician.</p>	<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) are covered. These therapies are covered in inpatient, outpatient and home settings and must be medically necessary and under the supervision or referral of a licensed physician.</p>	<p>Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (i.e. chemotherapy) are covered. These therapies are covered in inpatient, outpatient and home settings and must be medically necessary and under the supervision or referral of a licensed physician.</p>
<p>LIMITATION: Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Experimental or investigative drugs and protocols are excluded unless authorized by MetroPlus Utilization Management.</p>	<p>LIMITATION: Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Experimental or investigative drugs and protocols are excluded unless authorized by MetroPlus Utilization Management.</p>	<p>LIMITATION: Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Experimental or investigative drugs and protocols are excluded unless authorized by MetroPlus Utilization Management.</p>	<p>LIMITATION: Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Experimental or investigative drugs and protocols are excluded unless authorized by MetroPlus Utilization Management.</p>	<p>LIMITATION: Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Experimental or investigative drugs and protocols are excluded unless authorized by MetroPlus Utilization Management.</p>	<p>LIMITATION: Injectable chemotherapeutic drugs are covered when administered in an MD office and billed as part of an MD visit. Experimental or investigative drugs and protocols are excluded unless authorized by MetroPlus Utilization Management.</p>
<p>AUTHORIZATION: None</p>	<p>AUTHORIZATION: None</p>	<p>AUTHORIZATION: None</p>	<p>AUTHORIZATION: None</p>	<p>AUTHORIZATION: None</p>	<p>AUTHORIZATION: None</p>

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**BENEFIT: CHIROPRACTIC**

Not covered for adults.	Not covered for adults.	Not Covered.	Not Covered.	Not Covered.	Chiropractic services are only covered for detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
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LIMITATION: Covered only for persons under 21 years of age for the purpose of Early & Periodic Screening Diagnostic Testing (EPSDT) for physical and mental disabilities and conditions, when ordered by a physician.	LIMITATION: Covered only for persons under 21 years of age for the purpose of Early & Periodic Screening Diagnostic Testing (EPSDT) for physical and mental disabilities and conditions, when ordered by a physician.			LIMITATION: Covered only for persons under 21 years of age for the purpose of Early & Periodic Screening Diagnostic Testing (EPSDT) for physical and mental disabilities and conditions when ordered by a physician.	LIMITATION: Coverage is limited to treatment of conditions that, in the judgment of MetroPlus Utilization Management, are subject to significant clinical improvement within a reasonable period of time.
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AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.	AUTHORIZATION: Must be referred by Primary Care Provider. Authorization by MetroPlus Utilization Management required for all out-of-network services.
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**BENEFIT: DENTAL SERVICES**

<p>Not covered by MetroPlus but covered by Medicaid Fee For Service. To access a list of Medicaid dentists in NY, call 800-541-2831. Please see limitations and exclusions listed below.</p>	<p>Not covered by MetroPlus but covered by Medicaid Fee For Service. To access a list of Medicaid dentists in NY, call 800-541-2831. Please see limitations and exclusions listed below.</p>	<p>Dental Services are provided by DentaQuest.</p> <p>Routine dental care includes:</p> <ul style="list-style-type: none"> <li>- Dental examinations, visits and consultations covered once within six (6) month consecutive period (when primary teeth erupt)</li> <li>- X-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals or panoramic x-rays at 36 month intervals, if necessary, and other x-rays as required (once primary teeth erupt)</li> <li>- All necessary procedures for simple extractions and other routine dental surgery, including in-office conscious sedation</li> <li>- Amalgam or composite restorations and stainless steel crowns</li> <li>- Endodontics includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.</li> <li>- Other restorative materials appropriate for children</li> </ul> <p>Preventive dental care includes procedures which help prevent oral disease from occurring, including but not limited to:</p> <ul style="list-style-type: none"> <li>- Topical fluoride application at six (6) month intervals where local water supply is not fluoridated</li> <li>- Sealants on unrestored permanent molar teeth</li> <li>- Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.</li> </ul>	<p>Dental Services are provided by DentaQuest.</p> <p>Routine dental care including, but not limited to the following:</p> <ul style="list-style-type: none"> <li>- Prophylaxis every six (6) months</li> <li>- Topical fluoride applications at six (6) month intervals</li> <li>- Examinations, visits and consultations every six (6) months</li> <li>- Full mouth/panoramic x-rays every three (3) years if necessary, bitewing x-rays at 6-12 month intervals, other x-rays as required</li> <li>- Simple extractions and other routine dental surgery, including pre-postoperative care and in-office conscious sedation</li> <li>- Amalgam or composite restorations and stainless steel or porcelain fused to metal crowns</li> <li>- Endodontic procedures for treatment of diseased pulp chamber and pulp canals</li> <li>- Complete or partial dentures including six (6) months of follow-up care</li> <li>- Insertion of identification slips, repairs, relines and rebases</li> <li>- Treatment of cleft palate</li> </ul>	<p>Not covered by MetroPlus but covered by Medicaid Fee For Service. To access a list of Medicaid dentists in NY, call 800-541-2831. Please see limitations below.</p>	<p>Routine dental services are not covered by MetroPlus but may be covered by Union and/or Management Benefit Fund.</p>
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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: DENTAL SERVICES (continued)**

Prosthodontics includes removable complete or partial dentures including six (6) months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

**LIMITATION:** Inpatient dental surgery and ambulatory surgical procedures requiring anesthesia are covered in-network only. However, the professional services of the dentist are covered by Medicaid Fee For Service.

**LIMITATION:** Inpatient dental surgery and ambulatory surgical procedures requiring anesthesia are covered in-network only. However, the professional services of the dentist are covered by Medicaid Fee For Service.

**LIMITATION:** Inpatient dental surgery and ambulatory surgical procedures requiring anesthesia are covered in-network only.  
 Fixed bridges are not covered unless:  
 1. Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural functional and/or restored teeth  
 2. Required for cleft palate treatment or stabilization  
 3. Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.

**LIMITATION:** Inpatient dental surgery and ambulatory surgical procedures requiring anesthesia are covered in-network only. Fixed bridges are not covered unless required due to the presence of a neurologic or physiologic condition that would preclude the placement of a removable prosthesis.

**LIMITATION:** Inpatient dental surgery and ambulatory surgical procedures requiring anesthesia are covered in-network only. However, the professional services of the dentist are covered by Medicaid Fee For Service.

**LIMITATION:** - Treatment for accidental injury to sound natural teeth, the jaw bones or surrounding tissues within twelve (12) months of the accident as long as the member is covered at the time services are rendered.  
 - Treatment or correction of non-dental physiological condition that has resulted in severe functional impairment.  
 - Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of mouth.

**EXCLUSION:** Preventive and outpatient dentistry are excluded from the benefit package. Members can obtain them from any qualified Medicaid Fee For Service provider.

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**EXCLUSION:** Cosmetic dentistry, implants and orthodontia are not covered.

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**EXCLUSION:** Preventive and outpatient dentistry are excluded from the benefit package. Members can obtain them from any qualified Medicaid Fee For Service provider.

**EXCLUSION:** Preventive and outpatient dentistry are excluded from the benefit package.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: DIALYSIS</b>					
<p>Dialysis (i.e. hemodialysis and peritoneal dialysis) is covered when medically necessary as ordered by a qualified medical professional. Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.</p>	<p>Dialysis (i.e. hemodialysis and peritoneal dialysis) is covered when medically necessary as ordered by a qualified medical professional. Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.</p>	<p>Dialysis (i.e. hemodialysis and peritoneal dialysis) is covered when medically necessary as ordered by a qualified medical professional. Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.</p>	<p>Dialysis (i.e. hemodialysis and peritoneal dialysis) is covered when medically necessary as ordered by a qualified medical professional. Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.</p>	<p>Dialysis (i.e. hemodialysis and peritoneal dialysis) is covered when medically necessary as ordered by a qualified medical professional. Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.</p>	<p>Dialysis (i.e. hemodialysis and peritoneal dialysis) is covered when medically necessary as ordered by a qualified medical professional. Renal dialysis may be provided in an inpatient hospital setting, in an ambulatory care facility, or in the home on recommendation from a renal dialysis center.</p>
<p>LIMITATION: - Coverage is limited to the time period preceding the member becoming Medicare eligible. - Members who become eligible for Medicare are excluded from managed care and should be disenrolled.</p>	<p>LIMITATION: - Coverage is limited to the time period preceding the member becoming Medicare eligible. - Members who become eligible for Medicare are excluded from managed care and should be disenrolled.</p>	<p>LIMITATION: Patient may become eligible for Medicare, thereby eliminating Child Health Plus coverage.</p>	<p>LIMITATION: - Coverage is limited to the time period preceding the member becoming Medicare eligible. - Members who become eligible for Medicare are excluded from managed care and should be disenrolled.</p>	<p>LIMITATION: - Coverage is limited to the time period preceding the member becoming Medicare eligible. - Members who become eligible for Medicare are excluded from managed care and should be disenrolled.</p>	<p>LIMITATION: - Coverage is limited to the time period preceding the member becoming Medicare eligible. - Members who become eligible for Medicare are excluded from managed care and should be disenrolled.</p>
<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: Peritoneal dialysis per HPN.</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>
<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

<b>Medicaid Managed Care</b>	<b>Medicaid Managed Care w/SSI</b>	<b>Child Health Plus</b>	<b>Family Health Plus</b>	<b>HIV Special Needs Plan</b>	<b>MetroPlus Gold</b>
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**BENEFIT: DURABLE MEDICAL EQUIPMENT (DME)**

Durable Medical Equipment means devices and equipment (other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances) ordered by a practitioner for the treatment of a specific medical condition which:

- Can withstand repeated use for a protracted period of time;
- Are primarily and customarily used for medical purposes;
- Are generally not useful in the absence of illness or injury; and
- Are usually not fitted, designed or fashioned for a particular person's use

Durable Medical Equipment means devices and equipment (other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances) ordered by a practitioner for the treatment of a specific medical condition which:

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Durable Medical Equipment means devices and equipment (other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances) ordered by a practitioner for the treatment of a specific medical condition which:

- Can withstand repeated use for a protracted period of time;
- Are primarily and customarily used for medical purposes;
- Are generally not useful in the absence of illness or injury; and
- Are usually not fitted, designed or fashioned for a particular person's use

DME intended for use by one person may be customized or custom-made.

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DME includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME such as peak flow meters.

DME includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME such as peak flow meters.

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DME includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME such as peak flow meters.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: DURABLE MEDICAL EQUIPMENT (DME) (continued)</b>					
<p>DME coverage includes equipment servicing (parts &amp; labor). Examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Fitted/customized leg brace</li> <li>- Prosthetic arm</li> <li>- Footplate</li> <li>- Wheelchair</li> </ul>	<p>DME coverage includes equipment servicing (parts &amp; labor). Examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Fitted/customized leg brace</li> <li>- Prosthetic arm</li> <li>- Footplate</li> <li>- Wheelchair</li> </ul>	<p>DME coverage includes equipment servicing (parts &amp; labor). Examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Fitted/customized leg brace</li> <li>- Prosthetic arm</li> <li>- Footplate</li> <li>- Wheelchair</li> </ul>	<p>DME coverage includes equipment servicing (parts &amp; labor). Examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Fitted/customized leg brace</li> <li>- Prosthetic arm</li> <li>- Footplate</li> <li>- Wheelchair</li> </ul>	<p>DME coverage includes equipment servicing (parts &amp; labor). Examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Fitted/customized leg brace</li> <li>- Prosthetic arm</li> <li>- Footplate</li> <li>- Wheelchair</li> </ul>	<p>DME coverage includes equipment servicing (parts &amp; labor). Examples include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Fitted/customized leg brace</li> <li>- Prosthetic arm</li> <li>- Footplate</li> <li>- Wheelchair</li> <li>- Orthopedic shoes</li> </ul>
<p>LIMITATION: Equipment and supplies can only be obtained from a contracted vendor.</p>	<p>LIMITATION: Equipment and supplies can only be obtained from a contracted vendor.</p>	<p>LIMITATION: Equipment and supplies can only be obtained from a contracted vendor.</p>	<p>LIMITATION: Equipment and supplies can only be obtained from a contracted vendor.</p>	<p>LIMITATION: Equipment and supplies can only be obtained from a contracted vendor.</p>	<p>LIMITATION: Equipment and supplies can only be obtained from a contracted vendor.</p>
<p>EXCLUSION:</p> <ul style="list-style-type: none"> <li>- Standard household items (e.g. air conditioners)</li> <li>- Disposable medical supplies and enteral formula are covered by Medicaid Fee For Service with a provider's order.</li> </ul>	<p>EXCLUSION:</p> <ul style="list-style-type: none"> <li>- Standard household items (e.g. air conditioners)</li> <li>- Disposable medical supplies and enteral formula are covered by Medicaid Fee For Service with a provider's order.</li> </ul>	<p>EXCLUSION:</p> <ul style="list-style-type: none"> <li>- Standard household items (e.g. air conditioners)</li> <li>- Disposable medical supplies</li> </ul>	<p>EXCLUSION:</p> <ul style="list-style-type: none"> <li>- Standard household items (e.g. air conditioners)</li> <li>- Disposable medical supplies</li> <li>- Orthopedic shoes and diabetic shoes</li> </ul>	<p>EXCLUSION:</p> <ul style="list-style-type: none"> <li>- Standard household items (e.g. air conditioners)</li> <li>- Disposable medical supplies and enteral formula are covered by Medicaid Fee For Service with a provider's order.</li> </ul>	<p>EXCLUSION:</p> <ul style="list-style-type: none"> <li>- Standard household items (e.g. air conditioners)</li> <li>- Disposable medical supplies</li> </ul>
<p>Items listed in NY State Medicaid Program Description &amp; Coverage Guidelines, Sections 4.1 and 4.2 (<a href="http://www.emedny.org">www.emedny.org</a>) are not covered by MetroPlus, but covered by Medicaid Fee For Service.</p>	<p>Items listed in NY State Medicaid Program Description &amp; Coverage Guidelines, Sections 4.1 and 4.2 (<a href="http://www.emedny.org">www.emedny.org</a>) are not covered by MetroPlus, but covered by Medicaid Fee For Service.</p>	<p>Items listed in NY State Medicaid Program Description &amp; Coverage Guidelines, Sections 4.1 and 4.2 (<a href="http://www.emedny.org">www.emedny.org</a>) are not covered.</p>	<p>Items listed in NY State Medicaid Program Description &amp; Coverage Guidelines, Sections 4.1 and 4.2 (<a href="http://www.emedny.org">www.emedny.org</a>) are not covered.</p>	<p>Items listed in NY State Medicaid Program Description &amp; Coverage Guidelines, Sections 4.1 and 4.2 (<a href="http://www.emedny.org">www.emedny.org</a>) are not covered by MetroPlus, but covered by Medicaid Fee For Service.</p>	<p>Items listed in NY State Medicaid Program Description &amp; Coverage Guidelines, Sections 4.1 and 4.2 (<a href="http://www.emedny.org">www.emedny.org</a>) are not covered.</p>
<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all DME.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all DME.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all DME.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all DME.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all DME.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all DME.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: EMERGENCY DEPARTMENT (ED) SERVICES</b>					
ED services, in participating and non-participating facilities, are covered for medical or behavioral (i.e. psychiatric) conditions.	ED services, in participating and non-participating facilities, are covered for medical or behavioral (i.e. psychiatric) conditions.	ED services, in participating and non-participating facilities, are covered for medical or behavioral (i.e. psychiatric) conditions..	ED services, in participating and non-participating facilities, are covered for medical or behavioral (i.e. psychiatric) conditions.	ED services, in participating and non-participating facilities, are covered for medical or behavioral (i.e. psychiatric) conditions.	ED services, in participating and non-participating facilities, are covered for medical or behavioral (i.e. psychiatric) conditions.
The onset of these conditions can be sudden, manifesting itself by symptoms of sufficient severity, including severe pain that a prudent layperson could reasonably expect the absence of medical attention to result in: - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in jeopardy - Placing the health of the person afflicted with such condition in serious jeopardy	The onset of these conditions can be sudden, manifesting itself by symptoms of sufficient severity, including severe pain that a prudent layperson could reasonably expect the absence of medical attention to result in: - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in jeopardy - Placing the health of the person afflicted with such condition in serious jeopardy	The onset of these conditions can be sudden, manifesting itself by symptoms of sufficient severity, including severe pain that a prudent layperson could reasonably expect the absence of medical attention to result in: - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in jeopardy - Placing the health of the person afflicted with such condition in serious jeopardy	The onset of these conditions can be sudden, manifesting itself by symptoms of sufficient severity, including severe pain that a prudent layperson could reasonably expect the absence of medical attention to result in: - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in jeopardy - Placing the health of the person afflicted with such condition in serious jeopardy	The onset of these conditions can be sudden, manifesting itself by symptoms of sufficient severity, including severe pain that a prudent layperson could reasonably expect the absence of medical attention to result in: - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in jeopardy - Placing the health of the person afflicted with such condition in serious jeopardy	The onset of these conditions can be sudden, manifesting itself by symptoms of sufficient severity, including severe pain that a prudent layperson could reasonably expect the absence of medical attention to result in: - Placing the health of the person afflicted with such condition in serious jeopardy or in the case of a behavioral condition, placing the health of such person or others in jeopardy - Placing the health of the person afflicted with such condition in serious jeopardy
AUTHORIZATION: No authorization required.	AUTHORIZATION: No authorization required.	AUTHORIZATION: No authorization required.	AUTHORIZATION: No authorization required.	AUTHORIZATION: No authorization required.	AUTHORIZATION: No authorization required.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: EMERGENCY TRANSPORTATION</b>					
Emergency transportation by an ambulance service, including air ambulance is covered for purposes of providing transportation for the purpose of obtaining hospital services for an enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services.	Emergency transportation by an ambulance service, including air ambulance is covered for purposes of providing transportation for the purpose of obtaining hospital services for an enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services.	Non-airborne hospital transportation services are covered for prompt evaluation and treatment of an emergency condition.  Coverage for non-airborne emergency transportation is based a prudent layperson standard.	Emergency transportation by an ambulance service, including air ambulance is covered for purposes of providing transportation for the purpose of obtaining hospital services for an enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services.	Emergency transportation by an ambulance service, including air ambulance is covered for purposes of providing transportation for the purpose of obtaining hospital services for an enrollee who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services.	Non-airborne emergency transportation services to a hospital are covered.
All emergency ambulance services are covered.	All emergency ambulance services are covered.	All emergency ambulance services are covered. Transportation between two inpatient facilities is covered.	All emergency ambulance services are covered. Transportation between two inpatient facilities is covered.	All emergency ambulance services are covered.	All emergency ambulance services are covered.
LIMITATION: Services must be provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NYS Public Health Law.	LIMITATION: Services must be provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NYS Public Health Law.	LIMITATION: Services must be provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NYS Public Health Law.	LIMITATION: Services must be provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NYS Public Health Law.	LIMITATION: Services must be provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NYS Public Health Law.	LIMITATION: Services must be provided by an ambulance service issued a certificate to operate pursuant to Article 30, Section 3005 of the NYS Public Health Law.
EXCLUSION: None	EXCLUSION: None	EXCLUSION: Non-emergent transportation services.	EXCLUSION: Non-emergent transportation services.	EXCLUSION: None	EXCLUSION: Non-emergent transportation services.
AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: EPSDT SERVICES/CHILD TEEN HEALTH PROGRAM (C/THP)</b>					
<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a package of early and periodic screening, including inter-periodic screens, diagnostic and treatment services that NYS offers all Medicaid children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the NYS Department of Health.</p>	<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a package of early and periodic screening, including inter-periodic screens, diagnostic and treatment services the NYS offers all Medicaid children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the NYS Department of Health.</p>	<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a package of early and periodic screening, including inter-periodic screens, diagnostic and treatment services the NYS offers all Medicaid children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the NYS Department of Health.</p>	<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a package of early and periodic screening, including inter-periodic screens, diagnostic and treatment services the NYS offers all Medicaid children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the NYS Department of Health.</p>	<p>Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a package of early and periodic screening, including inter-periodic screens, diagnostic and treatment services the NYS offers all Medicaid children under 21 years of age. Care and services shall be provided in accordance with the periodicity schedule and guidelines developed by the NYS Department of Health.</p>	<p>Not covered.</p>
<p>The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.</p>	<p>The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.</p>	<p>The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.</p>	<p>The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.</p>	<p>The care includes necessary health care, diagnostic services, treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. The package of services includes administrative services designed to assist families obtain services for children that include outreach, education, appointment scheduling, administrative case management and transportation assistance.</p>	
<p>LIMITATION: Coverage for services not included in the managed care benefit package when ordered by the child's physician based on the results of a screening should be billed to Medicaid Fee For Service.</p>	<p>LIMITATION: Coverage for services not included in the managed care benefit package when ordered by the child's physician based on the results of a screening should be billed to Medicaid Fee For Service.</p>			<p>LIMITATION: Coverage for services not included in the managed care benefit package when ordered by the child's physician based on the results of a screening should be billed to Medicaid Fee For Service.</p>	
<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	
<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: FAMILY PLANNING & REPRODUCTIVE HEALTH CARE**

<p>Family planning means the offering, arranging, and furnishing of those health services which enable individuals, including minors, who may be sexually active, to prevent or reduce the incidence of unintended pregnancies and includes the screening, diagnosis and treatment, as medically necessary, for sexually transmissible diseases, sterilization services and screening for pregnancy. Reproductive health services also include all medically necessary abortions. Please note: elective, induced abortions must be covered for New York City residents.</p>	<p>Family planning means the offering, arranging, and furnishing of those health services which enable individuals, including minors, who may be sexually active, to prevent or reduce the incidence of unintended pregnancies and includes the screening, diagnosis and treatment, as medically necessary, for sexually transmissible diseases, sterilization services and screening for pregnancy. Reproductive health services also include all medically necessary abortions. Please note: elective, induced abortions must be covered for New York City residents.</p>	<p>Family planning means the offering, arranging, and furnishing of those health services which enable individuals, including minors, who may be sexually active, to prevent or reduce the incidence of unintended pregnancies and includes the screening, diagnosis and treatment, as medically necessary, for sexually transmissible diseases, sterilization services and screening for pregnancy.</p>	<p>Family planning means the offering, arranging, and furnishing of those health services which enable individuals, including minors, who may be sexually active, to prevent or reduce the incidence of unintended pregnancies and includes the screening, diagnosis and treatment, as medically necessary, for sexually transmissible diseases, sterilization services and screening for pregnancy. Reproductive health services also include all medically necessary abortions. Please note: elective, induced abortions must be covered for New York City residents.</p>	<p>Family planning means the offering, arranging, and furnishing of those health services which enable individuals, including minors, who may be sexually active, to prevent or reduce the incidence of unintended pregnancies and includes the screening, diagnosis and treatment, as medically necessary, for sexually transmissible diseases, sterilization services and screening for pregnancy. Reproductive health services also include all medically necessary abortions. Please note: elective, induced abortions must be covered for New York City residents.</p>	<p>Family planning coverage is provided for diagnosis, counseling, abortions and services when authorized by a Primary Care Provider or OB/GYN.</p>
<p>Enrollees may always obtain family planning and HIV testing and counseling services, when part of a family planning visit, outside of MetroPlus' network from any provider that accepts Medicaid.</p> <p>Any service provided in MD office is covered, e.g. intrauterine devices.</p>	<p>Enrollees may always obtain family planning and HIV testing and counseling services, when part of a family planning visit, outside of MetroPlus' network from any provider that accepts Medicaid.</p> <p>Any service provided in MD office is covered, e.g. intrauterine devices.</p>	<p>Any service provided in MD office is covered, e.g. intrauterine devices.</p>	<p>Any service provided in MD office is covered, e.g. intrauterine devices.</p>	<p>Enrollees may always obtain family planning and HIV testing and counseling services, when part of a family planning visit, outside of MetroPlus' network from any provider that accepts Medicaid.</p> <p>Any service provided in MD office is covered, e.g. intrauterine devices.</p>	<p>Infertility coverage, for members 21 - 44 years of age, is provided for the diagnosis and treatment of correctable medical conditions that would otherwise be covered benefits, when such medical condition results in infertility.</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>- Any service provided in MD office is covered, e.g. intrauterine devices</li> <li>- Surgical or medical procedures or care provided as part of hospital that could correct malformation, disease or dysfunction resulting in infertility</li> <li>- Services related to the diagnosis and treatment of infertility</li> <li>- Tests and procedures for the diagnosis of infertility, including hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, pelvic sonogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound</li> </ul>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: FAMILY PLANNING & REPRODUCTIVE HEALTH CARE (continued)**

Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.

Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.

Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.

Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.

Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.

LIMITATION: In network only.

LIMITATION: In network only.

LIMITATION: In network only.

**EXCLUSION:**  
 - Fertility Services  
 - In-vitro fertilization  
 - Sperm Banking  
 - Artificial Insemination  
 - Reversal of Sterilization

**EXCLUSION:**  
 - Fertility Services  
 - In-vitro fertilization  
 - Sperm Banking  
 - Artificial Insemination  
 - Reversal of Sterilization

**EXCLUSION:**  
 - Fertility Services  
 - In-vitro fertilization  
 - Sperm Banking  
 - Artificial Insemination  
 - Reversal of Sterilization

**EXCLUSION:**  
 - Fertility Services  
 - In-vitro fertilization  
 - Sperm Banking  
 - Artificial Insemination  
 - Reversal of Sterilization

**EXCLUSION:**  
 - Fertility Services  
 - In-vitro fertilization  
 - Sperm Banking  
 - Artificial Insemination  
 - Reversal of Sterilization

**EXCLUSION:** - In vitro fertilization, gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT)  
 - Reversal of elective sterilization  
 - Sex change procedures  
 - Cloning  
 - Medical or surgical services or procedures that are deemed experimental in accordance with the standards and guidelines established and adopted by the American College of Obstetricians and Gynecologists and the American Society for Reproductive Medicine

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: GYNECOLOGICAL SERVICES**

Members are entitled to two (2) routine preventive exams each year and any necessary follow-up care resulting from these examinations and for any acute problem.	Members are entitled to two (2) routine preventive exams each year and any necessary follow-up care resulting from these examinations and for any acute problem.	Members are entitled to two (2) routine preventive exams each year and any necessary follow-up care resulting from these examinations and for any acute problem.	Members are entitled to two (2) routine preventive exams each year and any necessary follow-up care resulting from these examinations and for any acute problem.	Members are entitled to two (2) routine preventive exams each year and any necessary follow-up care resulting from these examinations and for any acute problem.	Members are entitled to two (2) routine preventive exams each year and any necessary follow-up care resulting from these examinations and for any acute problem.
LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None
EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None
AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: HIV PRIMARY & SECONDARY PREVENTION & RISK-REDUCTION SERVICES**

Covered	Covered	Covered	Covered	<p>Coverage includes HIV primary and secondary prevention and risk-reduction education and counseling, education and counseling regarding reduction of perinatal transmission, harm reduction education and services, education to enrollees regarding STDs and services available for STD treatment and prevention, counseling and supportive services for partner/spousal notification.</p>	Covered
<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: HIV SPECIAL NEEDS PLAN CASE MANAGEMENT SERVICES**

Not Applicable	Not Applicable	Not Applicable	Not Covered	Coverage includes clinical coordination and medical/clinical case management in consultation with the Primary Care Provider (PCP). For example:	Not Applicable
See HIV SNP	See HIV SNP	See HIV SNP	See HIV SNP	<ul style="list-style-type: none"> <li>- Service utilization monitoring</li> <li>- Assessment and service plan development that address identified patient needs</li> <li>- Case manager involvement in quality assurance and continuous quality improvement</li> <li>- Non-intensive psychosocial case management as defined by the AIDS Institute's standards and guidelines</li> </ul>	See HIV SNP

## MetroPlus Covered Benefits by Line of Business (LOB)

<b>Medicaid Managed Care</b>	<b>Medicaid Managed Care w/SSI</b>	<b>Child Health Plus</b>	<b>Family Health Plus</b>	<b>HIV Special Needs Plan</b>	<b>MetroPlus Gold</b>
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**BENEFIT: HOME HEALTH SERVICES**

Services will be provided in the member's home by a Certified Home Health Agency (CHHA).

Services will be provided in the member's home by a Certified Home Health Agency (CHHA).

Coverage for up to 40 home health care visits per year. Services will be provided in the member's home by a Certified Home Health Agency (CHHA). Each visit by a Health Professional shall be considered as one home care visit and four hours of home health aide service shall be considered as one home care visit.

Coverage for up to 40 home health care visits per year in lieu of a skilled nursing facility stay or hospitalization. Services will be provided in the member's home by a Certified Home Health Agency (CHHA). Each visit by a Health Professional shall be considered as one home care visit and four hours of home health aide service shall be considered as one home care visit.

Services will be provided in the member's home by a Certified Home Health Agency (CHHA).

Coverage for up to 40 home health care visits per calendar year in lieu of a skilled nursing facility stay or hospitalization. Services will be provided in the member's home by a Certified Home Health Agency (CHHA). Each visit by a Health Professional shall be considered as one home care visit and four hours of home health aide service shall be considered as one home care visit.

Home health services mean the following services when prescribed by a provider and provided to a member in his/her home:

- Nursing services provided on a part-time or intermittent basis by a CHHA
- Physical therapy, occupational therapy or speech pathology and audiology services
- Medical equipment or appliances furnished as part of a home health visit
- Social work services and nutritional services furnished as part of a home health visit
- Personal care tasks performed by a home health aide incidental to a CHHA visit, and pursuant to an established care plan

Home health services mean the following services when prescribed by a provider and provided to a member in his/her home:

- Nursing services provided on a part-time or intermittent basis by a CHHA
- Physical therapy, occupational therapy or speech pathology and audiology services
- Medical equipment or appliances furnished as part of a home health visit
- Social work services and nutritional services furnished as part of a home health visit
- Personal care tasks performed by a home health aide incidental to a CHHA visit, and pursuant to an established care plan

Home health services mean the following services when prescribed by a provider and provided to a member in his/her home:

- Nursing services provided on a part-time or intermittent basis by a CHHA
- Physical therapy, occupational therapy or speech pathology and audiology services
- Medical equipment or appliances furnished as part of a home health visit
- Social work services and nutritional services furnished as part of a home health visit
- Personal care tasks performed by a home health aide incidental to a CHHA visit, and pursuant to an established care plan
- Drugs administered in the home are a covered benefit.

Home health services mean the following services when prescribed by a provider and provided to a member in his/her home:

- Nursing services provided on a part-time or intermittent basis by a CHHA
- Physical therapy, occupational therapy or speech pathology and audiology services
- Medical equipment or appliances furnished as part of a home health visit
- Social work services and nutritional services furnished as part of a home health visit
- Personal care tasks performed by a home health aide incidental to a CHHA visit, and pursuant to an established care plan

Home health services mean the following services when prescribed by a provider and provided to a member in his/her home:

- Nursing services provided on a part-time or intermittent basis by a CHHA
- Physical therapy, occupational therapy or speech pathology and audiology services
- Medical equipment or appliances furnished as part of a home health visit
- Social work services and nutritional services furnished as part of a home health visit
- Personal care tasks performed by a home health aide incidental to a CHHA visit, and pursuant to an established care plan

Home health services mean the following services when prescribed by a provider and provided to a member in his/her home:

- Skilled nursing care
- Home Health aide services
- Social work services
- Medical supplies, equipment and appliances to be used for the patient in the home
- Rehabilitation therapies in the home including physical, speech and occupational therapy
- Home infusion services and necessary DME required for the administration of the infused drug(s) when provided by Participating Provider
- Post-partum visits

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: HOME HEALTH SERVICES (continued)</b>					
<p>Additionally, two (2) post-partum home visits for high-risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery are covered. Visits must be made by a qualified health professional, the first visit to occur within forty-eight (48) hours of discharge.</p>	<p>Additionally, two (2) post-partum home visits for high-risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery are covered. Visits must be made by a qualified health professional, the first visit to occur within forty-eight (48) hours of discharge.</p>	<p>Additionally, two (2) post-partum home visits for high-risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery are covered. Visits must be made by a qualified health professional, the first visit to occur within forty-eight (48) hours of discharge.</p>	<p>Additionally, two (2) post-partum home visits for high-risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery are covered. Visits must be made by a qualified health professional, the first visit to occur within forty-eight (48) hours of discharge.</p>	<p>Additionally, two (2) post-partum home visits for high-risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery are covered. Visits must be made by a qualified health professional, the first visit to occur within forty-eight (48) hours of discharge.</p>	<p>Additionally, two (2) post-partum home visits for high-risk mothers, as well as to women with less than a forty-eight (48) hour hospital stay after a vaginal delivery or less than a ninety-six (96) hour stay after a cesarean delivery are covered. Visits must be made by a qualified health professional, the first visit to occur within forty-eight (48) hours of discharge.</p>
<p>LIMITATION: Drugs administered in the home are covered by Medicaid Fee For Service.</p>	<p>LIMITATION: Drugs administered in the home are covered by Medicaid Fee For Service.</p>	<p>LIMITATION: Forty (40) visits per calendar year.</p>	<p>LIMITATION: Forty (40) visits per calendar year. Drugs administered in the home are covered by Medicaid Fee For Service.</p>	<p>LIMITATION: Drugs administered in the home are covered by Medicaid Fee For Service.</p>	<p>LIMITATION: Forty (40) visits per year.</p>
<p>EXCLUSION: Personal care agency services.</p>	<p>EXCLUSION: Personal care agency services.</p>	<p>EXCLUSION: Personal care agency services</p>	<p>EXCLUSION: Personal care agency services</p>	<p>EXCLUSION: Personal care agency services</p>	<p>EXCLUSION: - Personal home health care services - Long-term home care</p>
<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all services.</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management for all services.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: HOSPICE SERVICES</b>					
<p>Not Covered. A member can access hospice services through the Medicaid Fee For Service program while continuing to remain enrolled in MetroPlus.</p>	<p>Not Covered. A member can access hospice services through the Medicaid Fee For Service program while continuing to remain enrolled in MetroPlus.</p>	<p>Coordinated hospice program (inpatient or home setting certified under Article 40 of NYS PHL) which provides non-curative medical and support services for persons certified terminally ill with a life expectancy of six (6) months or less.</p>	<p>Coordinated hospice program (inpatient or home setting certified under Article 40 of NYS PHL) which provides non-curative medical and support services for persons certified terminally ill with a life expectancy of six (6) months or less.</p>	<p>Not Covered. A member can access hospice services through the Medicaid Fee For Service program while continuing to remain enrolled in MetroPlus.</p>	<p>Terminally ill members are eligible for hospice care. A member is considered terminally ill if their Primary Care Provider has certified the member as having a life expectancy of six (6) months or less. All care must be provided by a certified hospice organization.</p>
		<p>Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family.</p>	<p>Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family.</p>		<p>Coverage is provided for the following services:                      - Inpatient care (in a hospice, SNF or a hospital) and outpatient care as determined by the PCP and approved by MetroPlus Utilization Management.                      - Drugs and medical supplies provided at the hospital or SNF.                      - Up to five (5) visits for bereavement counseling for family members before or after the death of the member.                      - End of Life Care: For members diagnosed with advanced cancer, End of Life coverage is provided for acute care services at an acute care facility licensed pursuant to Article 28 of the Public Health Law specializing in the treatment of terminally ill patients, if the member's specialist, in consultation with the Medical Director of such facility, determines that the member's care would appropriately be provided in the facility.</p>
		<p><b>LIMITATION:</b> Family members are eligible for up to five (5) visits for bereavement counseling.</p>	<p><b>LIMITATION:</b> Family members are eligible for up to five (5) visits for bereavement counseling.</p>		<p><b>LIMITATION:</b> Drugs are not provided in the home. Drugs are supplied by the Prescription Drug Rider.</p>
		<p><b>AUTHORIZATION:</b> Authorization required by MetroPlus Utilization Management.</p>	<p><b>AUTHORIZATION:</b> Authorization required by MetroPlus Utilization Management.</p>		<p><b>AUTHORIZATION:</b> Authorization required by MetroPlus Utilization Management.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: INPATIENT HOSPITAL CARE (Medical, Surgical, Mental Health & Substance Abuse Services)**

<p>Up to 365 days per year (366 days during leap year) for all medically necessary inpatient hospital services (including care, treatment, maintenance and nursing services as required). Other covered services can encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.</p>	<p>Up to 365 days per year (366 days during leap year) for all medically necessary inpatient hospital services (including care, treatment, maintenance and nursing services as required). Other covered services can encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.</p>	<p>Up to 365 days per year for all medically necessary inpatient hospital services provided by physicians and other professional personnel for covered inpatient services.</p>	<p>Up to 365 days per year (366 days during leap year) for all medically necessary inpatient hospital services (including care, treatment, maintenance and nursing services as required). Other covered services can encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.</p>	<p>Up to 365 days per year (366 days during leap year) for all medically necessary inpatient hospital services (including care, treatment, maintenance and nursing services as required). Other covered services can encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.</p>	<p>Up to 365 days per year (366 days during leap year) for all medically necessary inpatient hospital services (including care, treatment, maintenance and nursing services as required). Other covered services can encompass a full range of necessary diagnostic and therapeutic care including medical, surgical, nursing, radiological and rehabilitative services.</p>
<p>LIMITATION: - Reconstructive breast surgery is covered only for someone who has had a mastectomy or complication from previous breast implant.          - Breast reduction only if medically necessary.          - Private duty nursing only if medically necessary.          - Semi-private room unless a private room is medically necessary and ordered by the attending.          - Although generally excluded, experimental/investigational drugs and therapies are reviewed on a case-by-case basis.</p>	<p>LIMITATION: - Reconstructive breast surgery is covered only for someone who has had a mastectomy or complication from previous breast implant.          - Breast reduction only if medically necessary.          - Private duty nursing only if medically necessary.          - Semi-private room unless a private room is medically necessary and ordered by the attending.          - Although generally excluded, experimental/investigational drugs and therapies are reviewed on a case-by-case basis.</p>	<p>LIMITATION: - Reconstructive breast surgery is covered only for someone who has had a mastectomy or complication from previous breast implant.          - Breast reduction only if medically necessary.          - Semi-private room unless a private room is medically necessary and ordered by the attending.          - Although generally excluded, experimental/investigational drugs and therapies are reviewed on a case-by-case basis.</p>	<p>LIMITATION: - Reconstructive breast surgery is covered only for someone who has had a mastectomy or complication from previous breast implant.          - Breast reduction only if medically necessary.          - Private duty nursing only if medically necessary.          - Semi-private room unless a private room is medically necessary and ordered by the attending.          - Although generally excluded, experimental/investigational drugs and therapies are reviewed on a case-by-case basis.</p>	<p>LIMITATION: - Reconstructive breast surgery is covered only for someone who has had a mastectomy or complication from previous breast implant.          - Breast reduction only if medically necessary.          - Private duty nursing only if medically necessary.          - Semi-private room unless a private room is medically necessary and ordered by the attending.          - Although generally excluded, experimental/investigational drugs and therapies are reviewed on a case-by-case basis.</p>	<p>LIMITATION: - All medically necessary surgery is covered. Refer all questions about medical necessity to Utilization Management.          - Reconstructive breast surgery is covered only for someone who has had a mastectomy or complication from previous breast implant.          - Breast reduction only if medically necessary.          - Coverage is for a semi-private room unless a private room is medically necessary and ordered by the attending physician.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: INPATIENT HOSPITAL CARE (continued)**

**EXCLUSION:** - Cosmetic surgery  
 - Special blood products (e.g., autologous, family donations)  
 - Experimental and/or investigational drugs and therapies unless approved by MetroPlus Utilization Management

**EXCLUSION:** - Cosmetic surgery  
 - Special blood products (e.g., autologous, family donations)  
 - Experimental and/or investigational drugs and therapies unless approved by MetroPlus Utilization Management

**EXCLUSION:** - Cosmetic surgery  
 - Special blood products (e.g., autologous, family donations)  
 - Experimental/investigational drugs and therapies unless approved by MetroPlus Utilization Management  
 - Private duty nursing

**EXCLUSION:** - Cosmetic surgery  
 - Special blood products (e.g., autologous, family donations)  
 - Experimental and/or investigational drugs and therapies unless approved by MetroPlus Utilization Management

**EXCLUSION:** - Cosmetic surgery  
 - Special blood products (e.g., autologous, family donations)  
 - Experimental and/or investigational drugs and therapies

**EXCLUSION:** - Cosmetic surgery  
 - Experimental/investigational drugs and therapies unless approved by MetroPlus Utilization Management  
 - Private duty nursing

**AUTHORIZATION:** Authorization is not required for inpatient maternity and newborn services at HHC Facilities but is required for contracted and out-of-network facilities.

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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: LABORATORY SERVICES & PRE-SURGICAL TESTING (OUTPATIENT)**

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

All medically necessary testing. All tests (laboratory, x-ray, etc.) necessary for inpatient or outpatient surgery.

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional and listed in the Medicaid fee schedule for laboratory services.

Laboratory services include medically necessary tests and procedures ordered by a qualified medical professional.

**EXCLUSION:** HIV phenotypic and genotypic tests, HIV virtual phenotypic, HIV resistance tests and HIV viral tropism test. These tests are covered by Medicaid Fee For Service.

**EXCLUSION:** HIV phenotypic and genotypic tests, HIV virtual phenotypic, HIV resistance tests and HIV viral tropism test. These tests are covered by Medicaid Fee For Service.

**EXCLUSION:** HIV phenotypic and genotypic tests, HIV virtual phenotypic, HIV resistance tests and HIV viral tropism test. These tests are covered by Medicaid Fee For Service.

**EXCLUSION:** HIV phenotypic and genotypic tests, HIV virtual phenotypic, HIV resistance tests and HIV viral tropism test. These tests are covered by Medicaid Fee For Service.

**AUTHORIZATION:** None. Out-of-network testing is covered without authorization.

**AUTHORIZATION:** None. Out-of-network testing is covered without authorization.

**AUTHORIZATION:** None. Out-of-network testing is covered without authorization.

**AUTHORIZATION:** None. Out-of-network testing is covered without authorization.

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**AUTHORIZATION:** None. Out-of-network testing is covered without authorization.

## MetroPlus Covered Benefits by Line of Business (LOB)

<b>Medicaid Managed Care</b>	<b>Medicaid Managed Care w/SSI</b>	<b>Child Health Plus</b>	<b>Family Health Plus</b>	<b>HIV Special Needs Plan</b>	<b>MetroPlus Gold</b>
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**BENEFIT: MATERNITY CARE/PRENATAL CARE SERVICES/DELIVERY**

<p>Prenatal (including childbirth classes), labor and delivery are covered services.</p>	<p>Prenatal (including childbirth classes), labor and delivery are covered services.</p>	<p>Prenatal (including childbirth classes), labor and delivery are covered services.</p>	<p>Prenatal (including childbirth classes), labor and delivery are covered services.</p>	<p>Prenatal (including childbirth classes), labor and delivery are covered services.</p>	<p>Prenatal (including childbirth classes), labor and delivery are covered services.</p>
<p>Members are entitled to self-refer to a MetroPlus OB/GYN provider, including a licensed midwife, for prenatal care.</p>	<p>Members are entitled to self-refer to a MetroPlus OB/GYN provider, including a licensed midwife, for prenatal care.</p>	<p>Members are entitled to self-refer to a MetroPlus OB/GYN provider, including a licensed midwife, for prenatal care.</p>	<p>Members are entitled to self-refer to a MetroPlus OB/GYN provider, including a licensed midwife, for prenatal care.</p>	<p>Members are entitled to self-refer to a MetroPlus OB/GYN provider, including a licensed midwife, for prenatal care.</p>	<p>Members are entitled to self-refer to a MetroPlus OB/GYN provider, including a licensed midwife, for prenatal care.</p>
<p>All medically appropriate services related to the admission and necessary for the diagnosis and treatment of the member's condition in delivery. Includes:            - Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-section and in at least 96 hours following C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one (1) home care visit is covered post-discharge.            - Labor &amp; delivery, including cesarean            - Complications of pregnancy (e.g. miscarriage)            - Up to two (2) medically necessary post-partum home visits for high risk infants and mothers as well as to women with less than a 48 hour hospital stay after vaginal delivery or less than a 96 hour stay after a cesarean section.            - Newborn care</p>	<p>All medically appropriate services related to the admission and necessary for the diagnosis and treatment of the member's condition in delivery. Includes:            - Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-section and in at least 96 hours following C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one (1) home care visit is covered post-discharge.            - Labor &amp; delivery, including cesarean            - Complications of pregnancy (e.g. miscarriage)            - Up to two (2) medically necessary post-partum home visits for high risk infants and mothers as well as to women with less than a 48 hour hospital stay after vaginal delivery or less than a 96 hour stay after a cesarean section.            - Newborn Care</p>	<p>All medically appropriate services related to the admission and necessary for the diagnosis and treatment of the member's condition in delivery. Includes:            - Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-section and in at least 96 hours following C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one (1) home care visit is covered post-discharge.            - Maternal &amp; Newborn clinical assessment            - Labor &amp; delivery, including cesarean            - Complications of pregnancy (e.g. miscarriage)            - Up to two (2) medically necessary post-partum home visits for high risk infants and mothers as well as to women with less than a 48 hour hospital stay after vaginal delivery or less than a 96 hour stay after a cesarean section</p>	<p>All medically appropriate services related to the admission and necessary for the diagnosis and treatment of the member's condition in delivery. Includes:            - Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-section and in at least 96 hours following C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one (1) home care visit is covered post-discharge.            - Labor &amp; delivery, including cesarean            - Complications of pregnancy (e.g. miscarriage)            - Up to two (2) medically necessary post-partum home visits for high risk infants and mothers as well as to women with less than a 48 hour hospital stay after vaginal delivery or less than a 96 hour stay after a cesarean section</p>	<p>All medically appropriate services related to the admission and necessary for the diagnosis and treatment of the member's condition in delivery. Includes:            - Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-section and in at least 96 hours following C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one (1) home care visit is covered post-discharge.            - Labor &amp; delivery, including cesarean            - Complications of pregnancy (e.g. miscarriage)            - Up to two (2) medically necessary post-partum home visits for high risk infants and mothers as well as to women with less than a 48 hour hospital stay after vaginal delivery or less than a 96 hour stay after a cesarean section            - Newborn Care</p>	<p>All medically appropriate services related to the admission and necessary for the diagnosis and treatment of the member's condition in delivery. Includes:            - Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-section and in at least 96 hours following C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one (1) home care visit is covered post-discharge.            - Labor &amp; delivery, including cesarean            - Complications of pregnancy (e.g. miscarriage)            - Up to two (2) medically necessary post-partum home visits for high risk infants and mothers as well as to women with less than a 48 hour hospital stay after vaginal delivery or less than a 96 hour stay after a cesarean section            - Newborn Care</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: MATERNITY CARE/PRENATAL CARE SERVICES/DELIVERY (continued)**

If ordered by an OB/GYN or licensed midwife the following services are covered:

- All related laboratory tests
- All related diagnostic testing
- Nutritional counseling
- Sonograms
- Amniocentesis

If ordered by an OB/GYN or licensed midwife the following services are covered:

- All related laboratory tests
- All related diagnostic testing
- Nutritional counseling
- Sonograms
- Amniocentesis

If ordered by an OB/GYN or licensed midwife the following services are covered:

- All related laboratory tests
- All related diagnostic testing
- Nutritional counseling
- Sonograms
- Amniocentesis

If ordered by an OB/GYN or licensed midwife the following services are covered:

- All related laboratory tests
- All related diagnostic testing
- Nutritional counseling
- Sonograms
- Amniocentesis

If ordered by an OB/GYN or licensed midwife the following services are covered:

- All related laboratory tests
- All related diagnostic testing
- Nutritional counseling
- Sonograms
- Amniocentesis

If ordered by an OB/GYN or licensed midwife the following services are covered:

- All related laboratory tests
- All related diagnostic testing
- Nutritional counseling
- Sonograms
- Amniocentesis

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: MATERNITY CARE/PRENATAL CARE SERVICES/DELIVERY (continued)</b>					
Members are entitled to receive care in birthing centers if services are delivered by a physician or licensed midwife for prenatal care.	Members are entitled to receive care in birthing centers if services are delivered by a physician or licensed midwife for prenatal care.	Members are entitled to receive care in birthing centers if services are delivered by a physician or licensed midwife for prenatal care.	Members are entitled to receive care in birthing centers if services are delivered by a physician or licensed midwife for prenatal care.	Members are entitled to receive care in birthing centers if services are delivered by a physician or licensed midwife for prenatal care.	Members are entitled to receive care in birthing centers if services are delivered by a physician or licensed midwife for prenatal care.
Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.	Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.		Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.	Up to six (6) Smoking Cessation Counseling visits are a benefit for pregnant members.	
LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None
		EXCLUSION: - Newborns may not be MetroPlus members. - Home deliveries - Newborn nursery - Newborn hospital services other than clinical assessment - Subsidized children requiring maternity care services will be referred to Medicaid	EXCLUSION: Newborns of Family Health Plus members are not MetroPlus members.		
AUTHORIZATION: Authorization is not required for in-network maternity and newborn admissions. For out-of-network services, an authorization is required by MetroPlus Utilization Management. Deliveries in contracted facilities require authorization in order to pay non-participating physicians.	AUTHORIZATION: Authorization is not required for in-network maternity and newborn admissions. For out-of-network services, an authorization is required by MetroPlus Utilization Management. Deliveries in contracted facilities require authorization in order to pay non-participating physicians.	AUTHORIZATION: Authorization is not required for in-network maternity and newborn admissions. For out-of-network services, an authorization is required by MetroPlus Utilization Management. Deliveries in contracted facilities require authorization in order to pay non-participating physicians.	AUTHORIZATION: Authorization is not required for in-network maternity and newborn admissions. For out-of-network services, an authorization is required by MetroPlus Utilization Management. Deliveries in contracted facilities require authorization in order to pay non-participating physicians.	AUTHORIZATION: Authorization is not required for in-network maternity and newborn admissions. For out-of-network services, an authorization is required by MetroPlus Utilization Management. Deliveries in contracted facilities require authorization in order to pay non-participating physicians.	AUTHORIZATION: Authorization is not required for in-network maternity and newborn admissions. For out-of-network services, an authorization is required by MetroPlus Utilization Management. Deliveries in contracted facilities require authorization in order to pay non-participating physicians.
Note: If a member enters MetroPlus after 3 months of pregnancy and has been receiving prenatal care from a non-participating provider, the member has the right to continue to receive care from the non-participating provider on the condition that the non-participating provider is willing to accept MetroPlus reimbursement rates and cooperate with Quality Assurance and other MetroPlus administrative requirements.	Note: If a member enters MetroPlus after 3 months of pregnancy and has been receiving prenatal care from a non-participating provider, the member has the right to continue to receive care from the non-participating provider on the condition that the non-participating provider is willing to accept MetroPlus reimbursement rates and cooperate with Quality Assurance and other MetroPlus administrative requirements.	Note: If a member enters MetroPlus after 3 months of pregnancy and has been receiving prenatal care from a non-participating provider, the member has the right to continue to receive care from the non-participating provider on the condition that the non-participating provider is willing to accept MetroPlus reimbursement rates and cooperate with Quality Assurance and other MetroPlus administrative requirements.	Note: If a member enters MetroPlus after 3 months of pregnancy and has been receiving prenatal care from a non-participating provider, the member has the right to continue to receive care from the non-participating provider on the condition that the non-participating provider is willing to accept MetroPlus reimbursement rates and cooperate with Quality Assurance and other MetroPlus administrative requirements.	Note: If a member enters MetroPlus after 3 months of pregnancy and has been receiving prenatal care from a non-participating provider, the member has the right to continue to receive care from the non-participating provider on the condition that the non-participating provider is willing to accept MetroPlus reimbursement rates and cooperate with Quality Assurance and other MetroPlus administrative requirements.	Note: If a member enters MetroPlus after 3 months of pregnancy and has been receiving prenatal care from a non-participating provider, the member has the right to continue to receive care from the non-participating provider on the condition that the non-participating provider is willing to accept MetroPlus reimbursement rates and cooperate with Quality Assurance and other MetroPlus administrative requirements.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: MENTAL HEALTH SERVICES: See Behavioral Health Services**

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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: MIDWIFERY SERVICES**

<p>Midwifery Services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate.</p>	<p>Midwifery Services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate.</p>	<p>Midwifery Services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate.</p>	<p>Midwifery Services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate.</p>	<p>Midwifery Services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate.</p>	<p>Midwifery Services include the management of normal pregnancy, childbirth and postpartum care as well as primary preventive reproductive health care to essentially healthy women as specified in a written practice agreement and shall include newborn evaluation, resuscitation and referral for infants. The care may be provided on an inpatient or outpatient basis including in a birth center or in the recipient's home as appropriate.</p>
<p>LIMITATION: The midwife must be licensed by the State Department of Education.</p>	<p>LIMITATION: The midwife must be licensed by the State Department of Education.</p>	<p>LIMITATION: The midwife must be licensed by the State Department of Education.</p>	<p>LIMITATION: The midwife must be licensed by the State Department of Education.</p>	<p>LIMITATION: The midwife must be licensed by the State Department of Education.</p>	<p>LIMITATION: The midwife must be licensed by the State Department of Education.</p>
<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>
<p>AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.</p>	<p>AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.</p>	<p>AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.</p>	<p>AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.</p>	<p>AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.</p>	<p>AUTHORIZATION: Authorization by MetroPlus Utilization Management required for all out-of-network services.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: NEWBORN SERVICES**

Coverage includes:  
 - Pediatrician services in the hospital  
 - Inpatient nursery services  
 - Intensive care or other specialty services

Coverage includes:  
 - Pediatrician services in the hospital  
 - Inpatient nursery services  
 - Intensive care or other specialty services

Newborn may not be covered, check eligibility.

Newborn may not be covered, check eligibility.

Coverage includes:  
 - Pediatrician services in the hospital  
 - Inpatient nursery services  
 - Intensive care or other specialty services

Coverage includes:  
 - Pediatrician services in the hospital  
 - Inpatient nursery services  
 - Intensive care or other specialty services

LIMITATION: None

LIMITATION: None

LIMITATION: None

LIMITATION: None

EXCLUSION: None

EXCLUSION: None

EXCLUSION: None

EXCLUSION: None

AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.

AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.

AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.

AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT:** OBSTETRIC SERVICES: See Gynecological Services and Maternity Care/Prenatal Care/Services

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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PHYSICIAN SERVICES**

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<p>Covered whether provided in the office, the recipient's home, a hospital or a skilled nursing facility.</p>	<p>Covered whether provided in the office, the recipient's home, a hospital or a skilled nursing facility.</p>	<p>Covered whether provided in the office, the recipient's home, a hospital or a skilled nursing facility.</p>	<p>Covered whether provided in the office, the recipient's home, a hospital or a skilled nursing facility.</p>	<p>Covered whether provided in the office, the recipient's home, a hospital or a skilled nursing facility.</p>	<p>Covered whether provided in the office, the recipient's home, a hospital or a skilled nursing facility.</p>
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<p>Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under NYS Law.</p>	<p>Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under NYS Law.</p>	<p>Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under NYS Law.</p>	<p>Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under NYS Law.</p>	<p>Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under NYS Law.</p>	<p>Physician services include the full range of preventive care services, primary care medical services and physician specialty services that fall within a physician's scope of practice under NYS Law.</p>
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## MetroPlus Covered Benefits by Line of Business (LOB)

### Medicaid Managed Care

### Medicaid Managed Care w/SSI

### Child Health Plus

### Family Health Plus

### HIV Special Needs Plan

### MetroPlus Gold

#### **BENEFIT: PHYSICIAN SERVICES (continued)**

Physician Services includes:

- Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered
- Certain laboratory procedures performed as part of an office visit during the course of treatment are covered
- Physical examinations, including those necessary for employment, school and camp
- Physical and/or mental health or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for Federal SSI applications
- Annual preventive health visits for adolescents
- New admission exams for school children if required by the LDSS
- Health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms
- Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to children under twenty-one (21) years of age
- Family planning services including diagnosis, treatment and related counseling furnished as part of a physical exam

Physician Services includes:

- Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered
- Certain laboratory procedures performed as part of an office visit during the course of treatment are covered
- Physical examinations, including those necessary for employment, school and camp
- Physical and/or mental health or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for Federal SSI applications
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- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for Federal SSI applications
- Annual preventive health visits for adolescents;
- New admission exams for school children if required by the LDSS
- Health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms
- Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to children under twenty-one (21) years of age
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- Physical examinations, including those necessary for employment, school and camp
- Physical and/or mental health or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for Federal SSI applications
- Annual preventive health visits for adolescents;
- New admission exams for school children if required by the LDSS
- Health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms
- Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to children under twenty-one (21) years of age
- Family planning services including diagnosis, treatment and related counseling furnished as part of a physical exam

Physician Services includes:

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- Certain laboratory procedures performed as part of an office visit during the course of treatment are covered
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- Physical and/or mental health or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
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- Annual preventive health visits for adolescents
- New admission exams for school children if required by the LDSS
- Health screening, assessment and treatment of refugees, including completing SDOH/LDSS required forms
- Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to children under twenty-one (21) years of age
- Family planning services including diagnosis, treatment and related counseling furnished as part of a physical exam

Physician Services includes:

- Pharmaceuticals and medical supplies routinely furnished or administered as part of a clinic or office visit are covered
- Certain laboratory procedures performed as part of an office visit during the course of treatment are covered
- Physical examinations, including those necessary for employment, school and camp
- Physical and/or mental health or chemical dependence examinations of children and their parents as requested by the LDSS to fulfill its statutory responsibilities for the protection of children and adults and for children in foster care
- Health and mental health assessments for the purpose of making recommendations regarding a recipient's disability status for Federal SSI applications
- Annual preventive health visits for adolescents
- New admission exams for school children if required by the LDSS
- Health screening, assessment and treatment of refugees
- Child/Teen Health Program (C/THP) services which are comprehensive primary health care services provided to children under twenty-one (21) years of age
- Family planning services including diagnosis, treatment and related counseling furnished as part of a physical exam

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PHYSICIAN SERVICES (continued)**

Cardiac rehabilitation is an outpatient service designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered.

Cardiac rehabilitation is an outpatient service designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered.

Cardiac rehabilitation is an outpatient service designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered.

Cardiac rehabilitation is an outpatient service designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered.

Cardiac rehabilitation is an outpatient service designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered.

Cardiac rehabilitation is an outpatient service designed to both optimize a cardiac patient's physical, psychological and social functioning and stabilize, slow or reverse the progression of heart disease, reducing morbidity and mortality, is covered.

A second opinion from a participating provider is covered. See limitations.

A second opinion from a participating provider is covered. See limitations.

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A second opinion from a participating provider is covered. See limitations.

A second opinion from a participating provider is covered. See limitations.

A second opinion from a participating provider is covered. See limitations.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PHYSICIAN SERVICES (continued)**

<p>LIMITATION: MetroPlus requires a second opinion from a participating provider if the appropriate specialist is available in network.</p>	<p>LIMITATION: MetroPlus requires a second opinion from a participating provider if the appropriate specialist is available in network</p>	<p>LIMITATION: MetroPlus requires a second opinion from a participating provider if the appropriate specialist is available in network</p>	<p>LIMITATION: MetroPlus requires a second opinion from a participating provider if the appropriate specialist is available in network</p>	<p>LIMITATION: MetroPlus requires a second opinion from a participating provider if the appropriate specialist is available in network</p>	<p>LIMITATION: MetroPlus requires a second opinion from a participating provider if the appropriate specialist is available in network</p>
<p>EXCLUSION: Fertility services, such as GIFT, ZIFT and artificial insemination, are not covered.</p>	<p>EXCLUSION: Fertility services, such as GIFT, ZIFT and artificial insemination, are not covered.</p>	<p>EXCLUSION: None</p>	<p>EXCLUSION: Fertility services, such as GIFT, ZIFT and artificial insemination, are not covered.</p>	<p>EXCLUSION: Fertility services, such as GIFT, ZIFT and artificial insemination, are not covered.</p>	<p>EXCLUSION: Fertility services, such as GIFT, ZIFT and artificial insemination, are not covered.</p>
<p>AUTHORIZATION: Required by MetroPlus Utilization Management for all out-of-network services. Required by MetroPlus Utilization Management for surgical treatment of Erectile Dysfunction.</p>	<p>AUTHORIZATION: Required by MetroPlus Utilization Management for all out-of-network services. Required by MetroPlus Utilization Management for surgical treatment of Erectile Dysfunction.</p>	<p>AUTHORIZATION: Required by MetroPlus Utilization Management for all out-of-network services. Required by MetroPlus Utilization Management for surgical treatment of Erectile Dysfunction.</p>	<p>AUTHORIZATION: Required by MetroPlus Utilization Management for all out-of-network services. Required by MetroPlus Utilization Management for surgical treatment of Erectile Dysfunction.</p> <p>Family Health Plus members are required to make co-payments for certain medical care services. A detailed description is available in the MetroPlus Family Health Plus Member Handbook.</p>	<p>AUTHORIZATION: Required by MetroPlus Utilization Management for all out-of-network services. Required by MetroPlus Utilization Management for surgical treatment of Erectile Dysfunction.</p>	<p>AUTHORIZATION: Required by MetroPlus Utilization Management for all out-of-network services. Required by MetroPlus Utilization Management for surgical treatment of Erectile Dysfunction.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PODIATRY SERVICES**

Medically necessary services are covered.	Medically necessary services are covered.	Medically necessary services are covered.	Medically necessary services are covered.	Medically necessary services are covered.	Medically necessary services are covered.
EXCLUSION: Routine foot care including for care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic food strain or symptomatic complaints of the feet.	EXCLUSION: Routine foot care including for care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic food strain or symptomatic complaints of the feet.	EXCLUSION: Routine foot care including for care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic food strain or symptomatic complaints of the feet.	EXCLUSION: Routine foot care including or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic food strain or symptomatic complaints of the feet.	EXCLUSION: Routine foot care including or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic food strain or symptomatic complaints of the feet.	EXCLUSION: Routine foot care including or care in connection with any of the following: corns, calluses, flat feet, fallen arches, weak feet, chronic food strain or symptomatic complaints of the feet.
AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.	AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.	AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.	AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.	AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.	AUTHORIZATION: Authorization required by MetroPlus Utilization Management for out-of-network services.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PRESCRIPTION DRUGS**

<p>Not covered except for injectable drugs administered in an MD office. Please see exclusion listed below.</p>	<p>Not covered except for injectable drugs administered in an MD office. Please see exclusion listed below.</p>	<p>Prescription drugs must be medically necessary and are subject to formulary restrictions.</p>	<p>Not covered except for injectable drugs administered in an MD office.</p>	<p>Not covered except for injectable drugs administered in an MD office. Please see exclusion listed below.</p>	<p>FOR ALL MEMBERS WITH OR WITHOUT PRESCRIPTION DRUG RIDER:          - All medications and supplies for the treatment of diabetes are covered          - Injectable drugs administered in a doctor's office are covered</p>
<p>May obtain prescription drugs using Medicaid Fee for Service benefit.</p>	<p>May obtain prescription drugs using Medicaid Fee for Service benefit.</p>	<p>Prescription drugs may include, but are not limited to:          - Peak Flow Meters          - Family planning or contraceptive medications or devices          - All medications used for preventive and therapeutic purposes          - Modified solid food products that are low-protein or that contain modified protein are covered for individuals with certain inherited diseases of amino acid and organic acid metabolism.          - Enteral formulas for home use.</p> <p>Note: Benefit administered by informedRx with Formulary restrictions.</p>	<p>May obtain prescription drugs using Medicaid Fee for Service benefit.</p>	<p>May obtain prescription drugs using Medicaid Fee for Service benefit.</p>	<p>FOR MEMBERS WITH OPTIONAL PRESCRIPTION DRUG RIDER:          Coverage:          - Benefit administered by informedRx with Formulary restrictions.          - Thirty (30) day supply of prescription drugs purchased at a participating retail pharmacy.          - \$5 co-payment for each generic and brand name prescription.          - Full coverage of prescription drugs, with a prescription, that are purchased through MetroPlus' network of participating pharmacies.          - Enteral formulas that are medically necessary.          - Modified solid food products that are low protein or which contain modified protein are covered. These products cannot exceed \$2500 per member per calendar year.          - Bone mineral density prescription drugs.          - Coverage is provided for prescription contraceptive drugs or devices approved by the FDA or generic equivalents approved by the FDA.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care

Medicaid Managed Care w/SSI

Child Health Plus

Family Health Plus

HIV Special Needs Plan

MetroPlus Gold

**BENEFIT: PRESCRIPTION DRUGS (continued)**

LIMITATION: Benefit administered by informedRx with Formulary restrictions.  
 - Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively.  
 - Coverage for modified solid food products shall not exceed \$2500 per calendar year.  
 - Some OTC medications are provided with a prescription from the physician. OTC loratadine (Claratin) must be tried before MetroPlus Utilization Management will approve Zyrtec or Allegra.

LIMITATION: Benefit administered by informedRx with Formulary restrictions.  
 The Prescription Drug Rider does not cover:  
 - Any drug or device which does not require a prescription, even if a prescription is written.  
 - Replacements of drugs or devices resulting from loss, theft or breakage.  
 - OTC loratadine (Claratin) must be tried before MetroPlus Utilization Management will approve Zyrtec or Allegra.

EXCLUSION: All prescription drugs are covered by Medicaid Fee For Service.

EXCLUSION: All pharmacy services (e.g. prescriptions, over-the-counter medicines and some medical supplies) are covered by Medicaid Fee For Service.

Risperdal Consta (J2794) given in MD office is excluded and paid by Medicaid Fee For Service.

Risperdal Consta (J2794) given in MD office is excluded and paid by Medicaid Fee For Service.

EXCLUSION: - Vitamins are not covered except when necessary to treat a diagnosed illness or condition.

- Prescription drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.  
 - Erectile dysfunction drugs are not covered.  
 - Ostomy supplies are not covered.

EXCLUSION: All prescription drugs are covered by Medicaid Fee For Service.

Risperdal Consta (J2794) given in MD office is excluded and paid by Medicaid Fee For Service.

AUTHORIZATION: Authorization by informedRx is required for Botox, Lupron, Synagis.

AUTHORIZATION: Authorization by informedRx is required for Botox, Lupron, Synagis.

AUTHORIZATION: Authorization by informedRx is required for Botox, Lupron, Growth Hormone, Synagis.

Enteral formulas must be approved by informedRx.

AUTHORIZATION: Authorization by informedRx is required Botox, Lupron, Synagis.

AUTHORIZATION: Authorization by informedRx is required for Botox, Lupron, Synagis.

AUTHORIZATION: Authorization by informedRx is required for Botox, Lupron, Growth Hormone, Synagis.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PREVENTIVE CARE**

Preventive care means care and services to avert disease/illness and/or its consequences. There are three levels of preventive care:

1. primary, such as immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease
2. secondary, such as disease screening programs aimed at early detection of disease
3. tertiary, such as physical therapy, aimed at restoring function after the disease has occurred

Preventive care means care and services to avert disease/illness and/or its consequences. There are three levels of preventive care:

1. primary, such as immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease
2. secondary, such as disease screening programs aimed at early detection of disease
3. tertiary, such as physical therapy, aimed at restoring function after the disease has occurred

Well child care visits in accordance with visitation schedule established by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices recommended immunization schedule. There are three levels of preventive care:

1. primary, such as immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease
2. secondary, such as disease screening programs aimed at early detection of disease
3. tertiary, such as physical therapy, aimed at restoring function after the disease has occurred

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1. primary, such as immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease
2. secondary, such as disease screening programs aimed at early detection of disease
3. tertiary, such as physical therapy, aimed at restoring function after the disease has occurred

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PREVENTIVE CARE (continued)**

The following preventive services are included:

- General health education classes
- Pneumonia and influenza immunizations for at risk populations
- Up to 6 Smoking cessation visits, with targeted outreach for adolescents and pregnant women
- Childbirth education classes
- Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
- Nutrition counseling, with targeted outreach for diabetics and pregnant women
- Extended care coordination, as needed, for pregnant women
- HIV counseling and testing
- Immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease

The following preventive services are included in the managed care benefits package:

- General health education classes
- Pneumonia and influenza immunizations for at risk populations
- Up to 6 Smoking cessation visits, with targeted outreach for adolescents and pregnant women
- Childbirth education classes
- Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
- Nutrition counseling, with targeted outreach for diabetics and pregnant women
- Extended care coordination, as needed, for pregnant women
- HIV counseling and testing
- Immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease

The following preventive services are included:

- All services related to visits
- Immunizations which must be provided within 90 days from publication in the Morbidity and Mortality Weekly Report, and medically necessary vaccines, including Gardasil, aimed at preventing disease
- Well child care
- Health education
- Tuberculin testing (Mantoux)
- Hearing testing
- Dental and developmental screening
- Clinical laboratory and radiological tests
- Eye screening
- Lead screening
- Reproductive health services (direct access to such reproductive health services)
- Up to 6 Smoking cessation visits, with targeted outreach for adolescents and pregnant women

The following preventive services are included:

- General health education classes
- Pneumonia and influenza immunizations for at risk populations
- Up to 6 Smoking cessation visits, with targeted outreach for adolescents and pregnant women
- Childbirth education classes
- Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
- Nutrition counseling, with targeted outreach for diabetics and pregnant women
- Extended care coordination, as needed, for pregnant women
- HIV counseling and testing
- Immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease

The following preventive services are included:

- General health education classes
- Pneumonia and influenza immunizations for at risk populations
- Up to 6 Smoking cessation visits, with targeted outreach for adolescents and pregnant women
- Childbirth education classes
- Parenting classes covering topics such as bathing, feeding, injury prevention, sleeping, illness prevention, steps to follow in an emergency, growth and development, discipline, signs of illness, etc.
- Nutrition counseling, with targeted outreach for diabetics and pregnant women
- Extended care coordination, as needed, for pregnant women
- HIV counseling and testing
- Immunizations and medically necessary vaccines, including Gardasil, aimed at preventing disease

The following preventive services are included:

- Periodic health assessments for adults, based upon generally accepted guidelines relative to age, sex and medical history
- Biannual (twice a year) gynecological exams and preventive gynecologic services required as a result of such biannual examinations or as a result of an acute gynecologic condition, provided your provider discusses such services and treatment plan with your PCP
- Up to 6 Smoking cessation visits
- Well-child visits through age eighteen (18)
- Immunizations and vaccinations according to generally accepted medical practice standards including but not limited to all immunizations that are recommended by the American Academy of Pediatrics, including Gardasil
- On the recommendation of a Plan Provider, a mammogram at any age for members having a prior history of breast cancer or whose first degree relative has a prior history of breast cancer
- A single baseline mammogram for members age thirty-five (35) through thirty-nine (39)
- A mammogram every year for members age forty (40) and over
- No more than one (1) routine mammogram will be covered during a calendar year
- Bone density

Members with Diabetes or Asthma are entitled to Self-Management Classes for their respective diseases.

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# MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PREVENTIVE CARE (continued)**

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LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None
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EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None
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AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None	AUTHORIZATION: None
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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PRIVATE DUTY NURSING SERVICES**

<p>Private duty nursing services are covered in the member's home or in the hospital when determined to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided in accordance with a written treatment plan.</p>	<p>Private duty nursing services are covered in the member's home or in the hospital when determined to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided in accordance with a written treatment plan.</p>	<p>Not Covered</p>	<p>Not Covered</p>	<p>Private duty nursing services are covered in the member's home or in the hospital when determined to be medically necessary. Nursing services may be intermittent, part-time or continuous and provided in accordance with a written treatment plan.</p>	<p>Not covered</p>
<p>Private duty nursing services can be provided through an approved Certified Home Health Agency (CHHA), a licensed home care agency or a private Practitioner.</p>	<p>Private duty nursing services can be provided through an approved Certified Home Health Agency (CHHA), a licensed home care agency or a private Practitioner.</p>			<p>Private duty nursing services can be provided through an approved Certified Home Health Agency (CHHA), a licensed home care agency or a private Practitioner.</p>	
<p>LIMITATION: None</p>	<p>LIMITATION: None</p>			<p>LIMITATION: None</p>	
<p>EXCLUSION: None</p>	<p>EXCLUSION: None</p>			<p>EXCLUSION: None</p>	<p>EXCLUSION: Not covered</p>
<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management</p>	<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management.</p>			<p>AUTHORIZATION: Authorization required by MetroPlus Utilization Management.</p>	

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PROSTHETICS/ORTHOTICS AND OTHER APPLIANCES (part of DME benefit)**

Prosthetics are covered when medically necessary and include those appliances or devices which replace or perform the function of any missing part of the body.

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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: PROSTHETICS/ORTHOTICS AND OTHER APPLIANCES (continued)**

<p>Please note: Artificial eyes are covered.</p> <p>Orthotics are covered when medically necessary and include those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Includes: - Braces and Orthopedic footwear is covered when medically necessary.</p> <p>Includes: shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p> <p>Pacemaker services are covered.</p> <p>LIMITATION: Wigs are covered only for medically induced hair loss.</p> <p>EXCLUSION: Experimental or investigative prostheses or devices.</p> <p>AUTHORIZATION: All DME and orthotics require authorization by MetroPlus Utilization Management. Prosthetics must be provided by a Participating Provider that has received authorization from MetroPlus.</p>	<p>Please note: Artificial eyes are covered.</p> <p>Orthotics are covered when medically necessary and include those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Includes: - Braces and Orthopedic footwear is covered when medically necessary.</p> <p>Includes: shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p> <p>Pacemaker services are covered.</p> <p>LIMITATION: Wigs are covered only for medically induced hair loss.</p> <p>EXCLUSION: Experimental or investigative prostheses or devices.</p> <p>AUTHORIZATION: All DME and orthotics require authorization by MetroPlus Utilization Management. Prosthetics must be provided by a Participating Provider that has received authorization from MetroPlus.</p>	<p>Please note: Artificial eyes are covered.</p> <p>Orthotics are covered when medically necessary and include those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Includes: - Braces and Orthopedic footwear are covered when medically necessary.</p> <p>Includes: shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p> <p>Pacemaker services are covered.</p> <p>LIMITATION: Wigs are not covered.</p> <p>EXCLUSION: Experimental or investigative prostheses or devices.</p> <p>AUTHORIZATION: All DME and orthotics require authorization by MetroPlus Utilization Management. Prosthetics must be provided by a Participating Provider that has received authorization from MetroPlus.</p>	<p>Please note: Artificial eyes are covered.</p> <p>Orthotics are covered when medically necessary and include those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Includes: - Braces are covered when medically necessary.</p> <p>Includes: shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. Orthopedic shoes are not covered.</p> <p>Pacemaker services are covered.</p> <p>LIMITATION: Wigs are covered only for medically induced hair loss.</p> <p>EXCLUSION: Experimental or investigative prostheses or devices and orthopedic shoes.</p> <p>AUTHORIZATION: All DME and orthotics require authorization by MetroPlus Utilization Management. Prosthetics must be provided by a Participating Provider that has received authorization from MetroPlus.</p>	<p>Please note: Artificial eyes are covered.</p> <p>Orthotics are covered when medically necessary and include those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Includes: - Braces and Orthopedic footwear is covered when medically necessary.</p> <p>Includes: shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p> <p>Pacemaker services are covered.</p> <p>LIMITATION: Wigs are covered only for medically induced hair loss.</p> <p>EXCLUSION: Experimental or investigative prostheses or devices.</p> <p>AUTHORIZATION: All DME and orthotics require authorization by MetroPlus Utilization Management. Prosthetics must be provided by a Participating Provider that has received authorization from MetroPlus.</p>	<p>Please note: Artificial eyes are covered.</p> <p>Orthotics are covered when medically necessary and include those appliances or devices which are used for the purpose of supporting a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body.</p> <p>Orthopedic footwear is covered when medically necessary.</p> <p>Includes: shoes, shoe modifications, or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.</p> <p>Pacemaker services are covered.</p> <p>LIMITATION: Wigs are covered only for medically induced hair loss.</p> <p>EXCLUSION: Experimental or investigative prostheses or devices.</p> <p>AUTHORIZATION: All DME and orthotics require authorization by MetroPlus Utilization Management. Prosthetics must be provided by a Participating Provider that has received authorization from MetroPlus.</p>
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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: RADIOLOGY SERVICES</b>					
<p>Radiology Services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.</p>	<p>Radiology Services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.</p>	<p>Radiology Services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.</p>	<p>Radiology Services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.</p>	<p>Radiology Services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.</p>	<p>Radiology Services include medically necessary services provided by qualified practitioners in the provision of diagnostic radiology, diagnostic ultrasound, nuclear medicine, radiation oncology and magnetic resonance imaging (MRI). These services may only be performed upon the order of a qualified practitioner.</p>
<p>Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>- Routine x-ray</li> <li>- Diagnostic radiology</li> <li>- Mammography</li> <li>- Diagnostic ultrasound</li> <li>- Nuclear medicine</li> <li>- Radiation oncology</li> <li>- MRI</li> <li>- CT Scan</li> <li>- Bone density</li> </ul>	<p>Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>- Routine x-ray</li> <li>- Diagnostic radiology</li> <li>- Mammography</li> <li>- Diagnostic ultrasound</li> <li>- Nuclear medicine</li> <li>- Radiation oncology</li> <li>- MRI</li> <li>- CT Scan</li> <li>- Bone density</li> </ul>	<p>Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>- Routine x-ray</li> <li>- Diagnostic radiology</li> <li>- Mammography</li> <li>- Diagnostic ultrasound</li> <li>- Nuclear medicine</li> <li>- Radiation oncology</li> <li>- MRI</li> <li>- CT Scan</li> <li>- Bone density</li> </ul>	<p>Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>- Routine x-ray</li> <li>- Diagnostic radiology</li> <li>- Mammography</li> <li>- Diagnostic ultrasound</li> <li>- Nuclear medicine</li> <li>- Radiation oncology</li> <li>- MRI</li> <li>- CT Scan</li> <li>- Bone density</li> </ul>	<p>Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>- Routine x-ray</li> <li>- Diagnostic radiology</li> <li>- Mammography</li> <li>- Diagnostic ultrasound</li> <li>- Nuclear medicine</li> <li>- Radiation oncology</li> <li>- MRI</li> <li>- CT Scan</li> <li>- Bone density</li> </ul>	<p>Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>- Routine x-ray</li> <li>- Diagnostic radiology</li> <li>- Mammography</li> <li>- Ultrasound</li> <li>- Nuclear medicine</li> <li>- Radiation oncology</li> <li>- MRI</li> <li>- CT Scans</li> <li>- Bone density</li> </ul>
LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None	LIMITATION: None
EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None	EXCLUSION: None
<p><b>AUTHORIZATION:</b> Out-of-network services require authorization by MetroPlus Utilization Management except those associated with an ER visit.</p>	<p><b>AUTHORIZATION:</b> Out-of-network services require authorization by MetroPlus Utilization Management except those associated with an ER visit.</p>	<p><b>AUTHORIZATION:</b> Out-of-network services require authorization by MetroPlus Utilization Management except those associated with an ER visit.</p>	<p><b>AUTHORIZATION:</b> Out-of-network services require authorization by MetroPlus Utilization Management except those associated with an ER visit.</p>	<p><b>AUTHORIZATION:</b> Out-of-network services require authorization by MetroPlus Utilization Management except those associated with an ER visit.</p>	<p><b>AUTHORIZATION:</b> Out-of-network services require authorization by MetroPlus Utilization Management except those associated with an ER visit.</p>

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: REHABILITATION SERVICES (Medical Rehab; for Substance Abuse Rehab, see Behavioral Health)</b>					
Rehabilitation services are covered as medically necessary in an individual's home, inpatient or outpatient facility, in the office of a private practicing therapist or speech pathologist or in a Residential Health Care Facility (RHCF).	Rehabilitation services are covered as medically necessary in an individual's home, inpatient or outpatient facility, in the office of a private practicing therapist or speech pathologist or in a Residential Health Care Facility (RHCF).	Acute inpatient rehabilitation services are covered.	Rehabilitation services are covered as medically necessary in an individual's home, inpatient or outpatient facility, in the office of a private practicing therapist or speech pathologist or in a Residential Health Care Facility (RHCF).	Rehabilitation services are covered as medically necessary in an individual's home, inpatient or outpatient facility, in the office of a private practicing therapist or speech pathologist or in a Residential Health Care Facility (RHCF).	Rehabilitation services are covered as medically necessary in an individual's home, inpatient or outpatient facility, in the office of a private practicing therapist or speech pathologist or in a Residential Health Care Facility (RHCF).
Short term inpatient rehabilitation services are covered for the maximum reduction of physical or mental disability and restoration to the individual's best functional level.	Short term inpatient rehabilitation services are covered for the maximum reduction of physical or mental disability and restoration to the individual's best functional level.		Short term inpatient rehabilitation services are covered for the maximum reduction of physical or mental disability and restoration to the individual's best functional level.	Short term inpatient rehabilitation services are covered for the maximum reduction of physical or mental disability and restoration to the individual's best functional level.	Short term inpatient rehabilitation therapy that results in significant clinical improvement within a reasonable period of time (limitation-- not to exceed sixty (60) days) is covered. Maintenance therapy for chronic conditions is not a covered benefit. Speech therapy and services associated with a learning disability are not covered if such therapy or services are available through the school district according to NYS Public Health Law and/or the Federal Individuals with Disabilities Education Act (IDEA).
Short term outpatient occupational therapy and physical therapy is covered when ordered by a physician. Speech therapy is covered for conditions that will likely improve within a two (2) month period, beginning with the first day of therapy.	Short term outpatient occupational therapy and physical therapy is covered when ordered by a physician. Speech therapy is covered for conditions that will likely improve within a two (2) month period, beginning with the first day of therapy.	Short term outpatient occupational therapy and physical therapy is covered when ordered by a physician. Speech therapy is covered for conditions that will likely improve within a two (2) month period, beginning with the first day of therapy.	Short term outpatient occupational therapy, physical therapy and speech therapy is covered when ordered by a physician. Limitation: Limited to 20 visits per calendar year.	Short term outpatient occupational therapy and physical therapy is covered when ordered by a physician. Speech therapy is covered for conditions that will likely improve within a two (2) month period, beginning with the first day of therapy.	Short term outpatient rehab is limited to 20 visits per calendar year. Developmental delay coverage is provided for speech therapy services for children with developmental delay through age three (3) subject to the limitations noted above.
Cardiac rehabilitation is covered on an outpatient basis when prescribed by an approved specialist.	Cardiac rehabilitation is covered on an outpatient basis when prescribed by an approved specialist.	Cardiac rehabilitation is covered on an outpatient basis when prescribed by an approved specialist.	Cardiac rehabilitation is covered on an outpatient basis when prescribed by an approved specialist.	Cardiac rehabilitation is covered on an outpatient basis when prescribed by an approved specialist.	Cardiac rehabilitation is covered on an outpatient basis when prescribed by an approved specialist.
EXCLUSION: Permanent residency in a RHCF is not covered.	EXCLUSION: Permanent residency in a RHCF is not covered.	EXCLUSION: Rehabilitation in a RHCF is not covered.	EXCLUSION: Permanent Residency in a RHCF is not covered.	EXCLUSION: Permanent Residency in a RHCF is not covered.	EXCLUSION: Permanent Residency in a RHCF is not covered.
AUTHORIZATION: Authorization by MetroPlus Utilization Management is required for home and inpatient rehabilitation services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management is required for home and inpatient rehabilitation services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management is required for home and inpatient rehabilitation services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management is required for home and inpatient rehabilitation services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management is required for home and inpatient rehabilitation services.	AUTHORIZATION: Authorization by MetroPlus Utilization Management is required for home and inpatient rehabilitation services.

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: SKILLED NURSING FACILITY (SNF)</b>					
<p>The benefit provides all medically necessary services, custodial services and all skilled rehab services, until the member is able to return home.</p> <p>As long as there is potential for the member to return home, MetroPlus Utilization Management is responsible for determination of Medical Necessity and for Authorization of services.</p> <p>Custodial services provided to a member who is permanent resident in a Skilled Nursing Facility are not a MetroPlus benefit so will not be authorized. The member should be disenrolled by the facility and services will be paid by Medicaid Fee For Service.</p> <p>Note: Residential Health Care Facility, Skilled Nursing Facility and Nursing Home are terms that are often used interchangeably and they often provide both Skilled and Custodial Services.</p>	<p>The benefit provides all medically necessary services, custodial services and all skilled rehab services, until the member is able to return home.</p> <p>As long as there is potential for the member to return home, MetroPlus Utilization Management is responsible for determination of Medical Necessity and for Authorization of services.</p> <p>Custodial services provided to a member who is permanent resident in a Skilled Nursing Facility are not a MetroPlus benefit so will not be authorized. The member should be disenrolled by the facility and services will be paid by Medicaid Fee For Service.</p> <p>Note: Residential Health Care Facility, Skilled Nursing Facility and Nursing Home are terms that are often used interchangeably and they often provide both Skilled and Custodial Services.</p>	<p>Not Covered</p>	<p>The benefit provides all medically necessary services, custodial services and all skilled rehab services, until the member is able to return home.</p> <p>As long as there is potential for the member to return home, MetroPlus Utilization Management is responsible for determination of Medical Necessity and for Authorization of services.</p> <p>Custodial services provided to a member who is permanent resident in a Skilled Nursing Facility are not a MetroPlus benefit so will not be authorized. The member should be disenrolled by the facility and services will be paid by Medicaid Fee For Service.</p> <p>Note: Residential Health Care Facility, Skilled Nursing Facility and Nursing Home are terms that are often used interchangeably and they often provide both Skilled and Custodial Services.</p>	<p>The benefit provides all medically necessary services, custodial services and all skilled rehab services, until the member is able to return home.</p> <p>As long as there is potential for the member to return home, MetroPlus Utilization Management is responsible for determination of Medical Necessity and for Authorization of services.</p> <p>Custodial services provided to a member who is permanent resident in a Skilled Nursing Facility are not a MetroPlus benefit so will not be authorized. The member should be disenrolled by the facility and services will be paid by Medicaid Fee For Service.</p> <p>Note: Residential Health Care Facility, Skilled Nursing Facility and Nursing Home are terms that are often used interchangeably and they often provide both Skilled and Custodial Services.</p>	<p>Short term skilled nursing facility (SNF) care is covered when medically necessary. Skilled rehabilitation services must lead to rehabilitation and increased ability to function within a reasonable period of time.</p>
LIMITATION: None	LIMITATION: None		LIMITATION: None	LIMITATION: None	LIMITATION: Coverage is limited to 30 days per calendar year. Care in a SNF that does not meet the criteria for skilled services is considered custodial or domiciliary care and is not a covered benefit.
EXCLUSION: Permanent SNF care is not covered.	EXCLUSION: Permanent SNF care is not covered.		EXCLUSION: Permanent SNF care is not covered.	EXCLUSION: Permanent SNF care is not covered.	
AUTHORIZATION: Authorization is required by MetroPlus Utilization Management.	AUTHORIZATION: Authorization is required by MetroPlus Utilization Management.		AUTHORIZATION: Authorization is required by MetroPlus Utilization Management.	AUTHORIZATION: Authorization is required by MetroPlus Utilization Management.	AUTHORIZATION: Authorization is required by MetroPlus Utilization Management.

## MetroPlus Covered Benefits by Line of Business (LOB)

<b>Medicaid Managed Care</b>	<b>Medicaid Managed Care w/SSI</b>	<b>Child Health Plus</b>	<b>Family Health Plus</b>	<b>HIV Special Needs Plan</b>	<b>MetroPlus Gold</b>
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**BENEFIT: SPECIALTY CARE**

Coverage includes all specialty services referred by the Primary Care Provider (PCP).	Coverage includes all specialty services referred by the PCP.	Coverage includes all specialty services referred by the PCP.	Coverage includes all specialty services referred by the PCP.	Coverage includes all specialty services referred by the PCP.	Coverage includes all specialty services referred by the PCP.
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LIMITATION: - Out-of-network referrals require MetroPlus Utilization Management approval. - Chiropractic services are covered only for children under age 21, as part of the EPSDT program.	LIMITATION: - Out-of-network referrals require MetroPlus Utilization Management approval. - Chiropractic services are covered only for children under age 21, as part of the EPSDT program.	LIMITATION: - Out-of-network referrals require MetroPlus Utilization Management approval. - Chiropractic services are covered only for children under age 21, as part of the EPSDT program.	LIMITATION: - Out-of-network referrals require MetroPlus Utilization Management approval. - Chiropractic services are covered only for children under age 21, as part of the EPSDT program.	LIMITATION: - Out-of-network referrals require MetroPlus Utilization Management approval. - Chiropractic services are covered only for children under age 21, as part of the EPSDT program.	LIMITATION: Out-of-network referrals require MetroPlus Utilization Management approval.
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EXCLUSION: Cosmetic surgery.	EXCLUSION: Cosmetic surgery.	EXCLUSION: Cosmetic surgery.	EXCLUSION: Cosmetic surgery.	EXCLUSION: Cosmetic surgery.	EXCLUSION: Cosmetic surgery.
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AUTHORIZATION: Out-of-network services require authorization by MetroPlus Utilization Management.	AUTHORIZATION: Out-of-network services require authorization by MetroPlus Utilization Management.	AUTHORIZATION: Out-of-network services require authorization by MetroPlus Utilization Management.	AUTHORIZATION: Out-of-network services require authorization by MetroPlus Utilization Management.	AUTHORIZATION: Out-of-network services require authorization by MetroPlus Utilization Management.	AUTHORIZATION: Out-of-network services require authorization by MetroPlus Utilization Management.
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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: TRANSPORTATION, NON-EMERGENT**

<p>Transportation expenses are covered when transportation is essential in order for a member to obtain necessary medical care services.</p>	<p>Transportation expenses are covered when transportation is essential in order for a member to obtain necessary medical care services.</p>	<p>Not Covered</p>	<p>Not Covered</p>	<p>Transportation expenses are covered when transportation is essential in order for a member to obtain necessary medical care services.</p>	<p>Not Covered</p>
<p>Covers transportation services by ambulance, ambulette or invalid coach, taxicab, livery, public transportation or other means appropriate to the member's medical condition; and a transportation attendant to accompany the member, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary.</p>	<p>Covers transportation services by ambulance, ambulette or invalid coach, taxicab, livery, public transportation or other means appropriate to the member's medical condition; and a transportation attendant to accompany the member, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary.</p>			<p>Covers transportation services by ambulance, ambulette or invalid coach, taxicab, livery, public transportation or other means appropriate to the member's medical condition; and a transportation attendant to accompany the member, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary.</p>	
<p>For members with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.</p>	<p>For members with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.</p>			<p>For members with disabilities, the method of transportation must reasonably accommodate their needs, taking into account the severity and nature of the disability.</p>	
<p>LIMITATION: None</p>	<p>LIMITATION: None</p>			<p>LIMITATION: None</p>	
<p>EXCLUSION: No salary will be paid to a transportation attendant who is a family member of the enrollee.</p>	<p>EXCLUSION: No salary will be paid to a transportation attendant who is a family member of the enrollee.</p>			<p>EXCLUSION: No salary will be paid to a transportation attendant who is a family member of the enrollee.</p>	
<p>AUTHORIZATION: None</p>	<p>AUTHORIZATION: None</p>			<p>AUTHORIZATION: None</p>	

## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
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**BENEFIT: TREATMENT ADHERENCE SERVICES**

Not Covered	Not Covered	Not Covered	Not Covered	<p>Coverage includes treatment education policies and programs to encourage adherence to prescribed treatment regimes for all HIV SNP members, promotion of access to treatment adherence and supportive services integrated into the continuum of HIV care services and development of management and operation designs that promote coordination and unification of treatment adherence services. Treatment adherence services include development and regular reassessment of an individual treatment adherence plan for each member consistent with the guidelines as developed by the AIDS Institute.</p>	Not Covered
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## MetroPlus Covered Benefits by Line of Business (LOB)

Medicaid Managed Care	Medicaid Managed Care w/SSI	Child Health Plus	Family Health Plus	HIV Special Needs Plan	MetroPlus Gold
<b>BENEFIT: VISION CARE SERVICES</b>					
<p>All emergency, preventive and routine eye care are covered. Eye care includes the services of an optometrist, ophthalmologist and ophthalmic dispensers</p>	<p>All emergency, preventive and routine eye care are covered. Eye care includes the services of an optometrist, ophthalmologist and ophthalmic dispensers.</p>	<p>All emergency, preventive and routine eye care are covered. Eye care includes the services of an optometrist, ophthalmologist and ophthalmic dispensers.</p>	<p>All emergency, preventive and routine eye care are covered. Eye care includes the services of an optometrist, ophthalmologist and ophthalmic dispensers.</p>	<p>All emergency, preventive and routine eye care are covered. Eye care includes the services of an optometrist, ophthalmologist and ophthalmic dispensers.</p>	<p>All emergency, routine and preventive eye exams by a physician are covered. Services related to prosthetic eyes are covered.</p>
<p>Eye care services include:</p> <ul style="list-style-type: none"> <li>- Examinations to detect visual problems and/or eye disease.</li> <li>- Eyeglasses.</li> <li>- Contact lenses, Bifocals and polycarbonate lenses, if medically necessary.</li> <li>- Artificial eyes (stock or custom made).</li> <li>- Low vision aids and services.</li> <li>- Replacement of lost or damaged glasses.</li> </ul>	<p>Eye care services include:</p> <ul style="list-style-type: none"> <li>- Examinations to detect visual problems and/or eye disease.</li> <li>- Eyeglasses.</li> <li>- Contact lenses, Bifocals and polycarbonate lenses, if medically necessary.</li> <li>- Artificial eyes (stock or custom made).</li> <li>- Low vision aids and services.</li> <li>- Replacement of lost or damaged glasses.</li> </ul>	<p>Eye care services include:</p> <ul style="list-style-type: none"> <li>- Examinations to detect visual problems and/or eye disease.</li> <li>- Eyeglasses.</li> <li>- Contact lenses, Bifocals and polycarbonate lenses, if medically necessary.</li> </ul>	<p>Eye care services include:</p> <ul style="list-style-type: none"> <li>- Examinations to detect visual problems and/or eye disease every 24 months.</li> <li>- Eyeglasses every 24 months.</li> <li>- Contact lenses, Bifocals and polycarbonate lenses, if medically necessary.</li> <li>- Artificial eyes (stock or custom made).</li> <li>- Low vision aids and services.</li> </ul>	<p>Eye care services include:</p> <ul style="list-style-type: none"> <li>- Examinations to detect visual problems and/or eye disease.</li> <li>- Eyeglasses.</li> <li>- Contact lenses, Bifocals and polycarbonate lenses, if medically necessary.</li> <li>- Artificial eyes (stock or custom made).</li> <li>- Low vision aids and services.</li> <li>- Repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship</li> <li>- Replacement of lost or damaged glasses.</li> </ul>	
<p>Members with Diabetes may self refer to a participating provider for a Dilated Eye Exam by an Ophthalmologist or Optician.</p>	<p>Members with Diabetes may self refer to a participating provider for a Dilated Eye Exam by an Ophthalmologist or Optician.</p>		<p>Members with Diabetes may self refer to a participating provider for a Dilated Eye Exam by an Ophthalmologist or Optician.</p>	<p>Members with Diabetes may self refer to a participating provider for a Dilated Eye Exam by an Ophthalmologist or Optician.</p>	

## MetroPlus Covered Benefits by Line of Business (LOB)

<b>Medicaid Managed Care</b>	<b>Medicaid Managed Care w/SSI</b>	<b>Child Health Plus</b>	<b>Family Health Plus</b>	<b>HIV Special Needs Plan</b>	<b>MetroPlus Gold</b>
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**BENEFIT: VISION CARE SERVICES**

**LIMITATION:** - Only approved eyeglass frames (i.e. Medicaid approved) will be covered.

- Replacement glasses should duplicate the original prescription and frames.
- Examinations which include refraction are limited to every two (2) years unless otherwise justified as medically necessary.
- Only one (1) pair of eyeglasses every two (2) years unless medically indicated (e.g. such as a change in correction greater than 1/2 diopter or unless the glasses are lost, damaged or destroyed).
- Contact lenses and tinted lenses may be covered when medically necessary to treat a pathology (e.g. cataract)

**LIMITATION:** - Only approved eyeglass frames (i.e. Medicaid approved) will be covered.

- Replacement glasses should duplicate the original prescription and frames.
- Examinations which include refraction are limited to every two (2) years unless otherwise justified as medically necessary.
- Only one (1) pair of eyeglasses every two (2) years unless medically indicated (e.g. such as a change in correction greater than 1/2 diopter or unless the glasses are lost, damaged or destroyed).
- Contact lenses and tinted lenses may be covered when medically necessary to treat a pathology (e.g. cataract)

**LIMITATION:** - Only approved eyeglass frames will be covered.

- Replacement glasses should duplicate the original prescription and frames.
- Only one (1) pair of eyeglasses every year unless the prescription changes and is required more frequently with appropriate documentation. If medically necessary, more than one (1) pair of glasses will be covered.
- Contact lenses and tinted lenses may be covered when medically necessary to treat a pathology (e.g. cataract)

**LIMITATION:** - Only approved eyeglass frames (i.e. Medicaid approved) will be covered.

- Replacement glasses should duplicate the original prescription and frames.
- Examinations which include refraction are limited to every two (2) years unless otherwise justified as medically necessary.
- Only one (1) pair of eyeglasses every two (2) years.
- Contact lenses and tinted lenses may be covered when medically necessary to treat a pathology (e.g. cataract)

**LIMITATION:** - Only approved eyeglass frames (i.e. Medicaid approved) will be covered.

- Replacement glasses should duplicate the original prescription and frames.
- Examinations which include refraction are limited to every two (2) years unless otherwise justified as medically necessary.
- Only one (1) pair of eyeglasses every two (2) years unless medically indicated (e.g. such as a change in correction greater than 1/2 diopter or unless the glasses are lost, damaged or destroyed).
- Contact lenses and tinted lenses may be covered when medically necessary to treat a pathology (e.g. cataract)

**EXCLUSION:** - Upgraded eyeglasses (e.g. designer eyeglass frames) or additional features such as scratch coating or photo-gray lenses are not covered. The member may choose to purchase upgraded eyeglass frames or features by paying the entire cost as a private customer.

- Progressive lenses.

**EXCLUSION:** - Upgraded eyeglasses (e.g. designer eyeglass frames) or additional features such as scratch coating or photo-gray lenses are not covered. The member may choose to purchase upgraded eyeglass frames or features by paying the entire cost as a private customer.

- Progressive lenses.

**EXCLUSION:** - Upgraded eyeglasses (e.g. designer eyeglass frames) or additional features such as scratch coating or photo-gray lenses are not covered. The member may choose to purchase upgraded eyeglass frames or features by paying the entire cost as a private customer.

- Progressive lenses.

**EXCLUSION:** - Upgraded eyeglasses (e.g. designer eyeglass frames) or additional features such as scratch coating or photo-gray lenses are not covered. The member may choose to purchase upgraded eyeglass frames or features by paying the entire cost as a private customer.

- No replacement of lost or damaged frames or lenses.
- Progressive lenses.

**EXCLUSION:** - Upgraded eyeglasses (e.g. designer eyeglass frames) or additional features such as scratch coating or photo-gray lenses are not covered. The member may choose to purchase upgraded eyeglass frames or features by paying the entire cost as a private customer.

- Progressive lenses.

**EXCLUSION:** Refractive services for glasses and contact lenses and eyewear are not covered.

**AUTHORIZATION:** None

**AUTHORIZATION:** None

**AUTHORIZATION:** None

**AUTHORIZATION:** None

**AUTHORIZATION:** None

**AUTHORIZATION:** None