



2026 Summary of Benefits

Louisiana (LA01)

Service Area: Ascension, East Baton
Rouge, Iberville, and West Baton
Rouge counties.

This booklet provides you with a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the *Evidence of Coverage* (EOC) or visit us at www.amerihealthcaritasvipcare.com/la.

Who can join AmeriHealth Caritas VIP Care?

To join AmeriHealth Caritas VIP Care, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be enrolled in the Louisiana Medicaid Program. You must qualify for Medical Assistance in one of the following categories of aid:

- Qualified Medicare Beneficiary Plus (QMB+).
- Specified Low-Income Medicare Beneficiary Plus (SLMB+).
- Full Benefit Dual Eligible (FBDE).

You must live in our service area. Our service area includes the following counties in Louisiana: **Ascension, East Baton Rouge, Iberville, West Baton Rouge.**

For prospective enrollees, if you have questions about your eligibility, call **1-800-464-3829 (TTY 711)**.

Which doctors, hospitals, and pharmacies can I use?

- AmeriHealth Caritas VIP Care has a network of doctors, hospitals, pharmacies, and other providers. You must receive your care from a network provider. We will only pay for covered services if you go to an in-network provider. In most cases, you will have to pay for care that you receive from an out-of-network provider. Out-of-network/non-contracted providers are under no obligation to treat AmeriHealth Caritas VIP Care members, except in emergency situations. Please call our Member Services number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.
- You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.
- You can view our plan's Provider and Pharmacy Directories on our website, www.amerihealthcaritasvipcare.com/la.
- You can also call us, and we will send you a copy of the Provider and Pharmacy Directories.

What we cover

- Like all Medicare health plans, we cover everything that Original Medicare covers — and more.
 - Our plan members get all the benefits covered by Original Medicare.
 - Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet.
- We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.
 - You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.amerihealthcaritasvipcare.com/la.
 - You can also call us, and we will send you a copy of the formulary.

How will I determine my drug costs?

- Our plan groups all medications into one of six tiers. The cost of your drugs will depend on the level of “Extra Help” you receive and what tier they are in.

Plan Premium, Deductible, and Maximum Out-of-Pocket (MOOP)



Premiums, copays, coinsurance, and deductibles may vary based on your Medicaid eligibility category and/or the level of Extra Help you receive.

Monthly Plan Premium	You pay \$0 (You must continue to pay your Medicare Part B premium, if not otherwise paid for by Medicaid or another third party.)
Deductible	This plan does not have a deductible.
Maximum Out-of-Pocket Responsibility	In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid eligibility. Your yearly limit(s) in this plan: \$9,250 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services, and we will pay the full cost for the rest of the year.

Covered Medical and Hospital Benefits



Hospital coverage

Inpatient Hospital Coverage	\$0 copay per stay <i>Prior authorization is required.</i>
Outpatient Hospital Coverage	\$0 copay This includes medically necessary services for diagnosis or treatment of an illness or injury. <i>Not all outpatient preventive or diagnostic services will require authorization.</i>
Ambulatory Surgical Center (ASC) Services	\$0 copay <i>Prior authorization may be required.</i>



Doctor Visits

Doctor Visits (Primary Care Providers and Specialists)	• Primary care provider (PCP) visit: \$0 copay per visit • Annual Wellness visit: \$0 copay per visit • Specialist care: \$0 copay per visit
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Preventive

Any additional preventive services approved by Medicare during the contract year will be covered.

Preventive Care	\$0 copay
	• Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screening • Cervical and vaginal cancer screening • Colorectal cancer Screening (colonoscopy, fecal occult blood test flexible sigmoidoscopy) • Depression screening • Diabetes screening • Diabetes self-management training • Diabetic services and supplies • Health and wellness education programs • HIV screening • Lung cancer screening • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and counseling • Prostate cancer screening (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease): -Four additional face-to-face PCP visits for smoking/tobacco cessation annually • Vaccines, including flu shots, hepatitis B shots, pneumococcal shots, COVID-19 vaccines • Vision care • Welcome to Medicare preventive visit (one time)



Emergency and Urgent Care

Emergency Care	\$0 copay Cost-sharing for necessary emergency services furnished out of network is the same as that for such services furnished in-network.
Urgently Needed Services	\$0 copay This includes services needed to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Cost sharing for necessary urgently needed services furnished out of network is the same as that for such services furnished in-network.



Diagnostic Services, Labs and Imaging

Diagnostic Services/ Labs/Imaging (including diagnostic tests and procedures, labs, diagnostic radiology, and X-rays)	\$0 copay Covered services include, but are not limited to: • Diagnostic tests and procedures. • Laboratory tests. • Diagnostic radiology services (such as magnetic resonance imaging [MRI], magnetic resonance angiography [MRA], computed tomography [CT], and positron emission tomography [PET]) • Outpatient X-rays. <i>Prior authorization may be required.</i>
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Hearing Services

Hearing Services	• \$0 copay for up to one routine hearing exam every year. • \$2,000 allowance for two non-implantable TruHearing branded Advanced hearing aids every three years (limit one hearing aid per ear). The allowance covers the cost of two [2] non-implantable TruHearing branded Advanced hearing aid[s] every three [3] years (limit 1 hearing aid per ear). After plan-paid benefit, you are responsible for the remaining costs. * You must see a TruHearing provider to use this benefit. Hearing aid purchase includes: - First 12 months of follow-up provider visits - 60-day trial period - 3-year extended warranty - 80 batteries per aid for non-rechargeable models Benefit does not include or cover any of the following: Over the counter (OTC) hearing aids, ear molds, hearing aid accessories, additional provider visits, additional batteries, batteries when a rechargeable hearing aid is purchased, hearing aids that are not TruHearing-branded Advanced Aids, costs associated with loss & damage warranty claims. Costs associated with excluded items are the responsibility of the member and not covered by the plan. * Remaining costs refers to any amount more than your allowance Services not covered under any condition: Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), over the counter (OTC) hearing aids, ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).
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Dental Services

Dental Services	We cover the following services: Preventive: • Oral exams – one every six months: \$0 copay • Cleaning – one every six months: \$0 copay • Fluoride treatment – one every six months: \$0 copay • Dental X-rays – one every five years (frequency varies by service): \$0 copay Comprehensive: • Minor restorations (fillings). • Simple and Surgical extractions. • Dentures (1 per arch every 5 years). • Denture repair and reline. • Oral surgery. • Periodontics/endodontics. • Crowns. • Mini-implants. \$3,000 plan coverage limit for comprehensive dental benefits every year. <i>Prior authorization and limits may apply for some comprehensive dental services. You are responsible for amounts beyond the benefit limit.</i>
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Vision Services

Vision Services	• \$0 copay for Medicare-covered diagnosis and treatment for diseases and conditions of the eye. • \$0 copay for up to one routine vision exam every year. • Up to \$400 every year towards eyeglasses or contact lenses. <i>The benefit amount (allowance) must be used to pay for vision services from an in-network provider. In most cases, you will have to pay for care that you receive from an out-of-network provider. You are responsible for amounts beyond the benefit limit.</i>
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Mental Health Services

Mental Health Services	\$0 copay • Inpatient visit. • Outpatient group therapy visit. • Outpatient individual therapy visit.
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Skilled Nursing Facility (SNF) and Therapy

Skilled Nursing Facility (SNF)	\$0 copay Our plan covers up to 100 days in an SNF per admission. <i>Prior authorization is required.</i>
Physical Therapy	\$0 copay • Occupational therapy • Speech therapy <i>Prior authorization is required.</i>



Ambulance and Non-Emergency Transportation

Ambulance	\$0 copay <i>Prior authorization may be required.</i>
Transportation	\$0 copay 40 one-way trips to plan-approved locations every year (e.g., doctor's office, pharmacy, and hospital. May consist of a car, shuttle, or van service, depending on appropriateness for the situation and the member's needs.) <i>Rides must be scheduled at least one business day in advance except in special circumstances. Limit of 100 miles per one-way trip.</i>



Medicare Part B Drugs

Medicare Part B Drugs	\$0 copay • Preferred Chemotherapy drugs. • Preferred Other Part B drugs. <i>Prior authorization is required.</i> <i>20% coinsurance will be applied to non-preferred chemotherapy and non-preferred other Part B drugs.</i>
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Medicare Part D Drugs



AmeriHealth Caritas VIP Care covers a wide range of prescription drugs. They can include medicines you take every day to improve your health and well-being.

IMPORTANT : If you receive assistance from Medicaid or "Extra Help," you may pay less than the cost-sharing amounts listed in this document. If your category of Medicaid eligibility or level of Extra Help changes, your cost share may increase or decrease. Please refer to the <i>Evidence of Coverage</i> for additional benefit details.	
Yearly Deductible stage	\$615 for Tiers 1-5, only if you receive "Extra Help" from Medicare, your deductible is \$0. The deductible does not apply to tier 6.
Initial Coverage stage	- Tiers 1-5: 0-25% coinsurance - Tier 6: \$0 copay -You can get a 30, 60 or up to 100-day supply of drugs at a retail pharmacy and 61 to 100-day supply of drugs using a mail-order prescription.
Catastrophic Coverage stage	\$0 copay per prescription

To find which pharmacies are available in your network, go to www.amerihealthcaritasvipcare.com/la.

Additional Covered Benefits



Additional Smoking and Tobacco Use Cessation	\$0 copay Four additional face-to-face primary care provider visits for smoking/tobacco cessation annually. This is in addition to Medicare's eight covered visits, for a total of 12 visits in a 12-month period.
Chiropractic Care	\$0 copay The plan covers manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position).
Fitness Benefit	\$0 copay SilverSneakers® is a free fitness benefit which includes access to participating SilverSneakers® fitness facilities, online wellness resources, and classes.
Home Health Care	\$0 copay Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <i>Prior authorization is required.</i>



Additional Covered Benefits continued...

Meal Benefit, post-discharge	\$0 copay The post-discharge meal benefit covers 14 meals over the course of one week for qualified homebound members after each discharge from an inpatient facility or a skilled nursing facility. Up to four times per year. <i>A referral is required.</i>
Medical Equipment/Supplies	\$0 copay • Durable Medical Equipment (e.g., wheelchairs and oxygen). • Prosthetics (e.g., braces, artificial limbs, and breast prostheses). <i>Prior Authorization is required for:</i> • Medicare-covered DME items over \$750 for purchase. • Rental and rent-to-purchase items. • The purchase of all wheelchairs (motorized and manual) and all wheelchair accessories (components) regardless of cost per item • Enteral Nutritional Supplements • Non-Preferred Diabetic Supplies and Continuous Glucose Monitors (20% coinsurance will apply)
Opioid Treatment Program Services	\$0 copay • Substance use counseling. • Individual and group therapy. • Toxicology testing.



Additional Covered Benefits continued...

Outpatient Rehabilitation	\$0 copay • Cardiac (heart) rehabilitation services. • Physical therapy <i>Prior authorization is required.</i>
Over-the-counter Items (OTC)	\$45 per month to spend on eligible OTC items such as vitamins, pain relievers, cold remedies, and more. Funds are loaded to a plan-issued debit card each month. • You can shop through the OTC catalog or at participating retail stores • No limit on the number of items or orders • Unused amounts expire at the end of each month or upon disenrollment from the plan
Podiatry Services	\$0 copay Three routine foot care visits every year.



Additional Covered Benefits continued...

SSBCI	<u>SSBCI</u> If you qualify for SSBCI, you receive a \$70 monthly credit to help with everyday living expenses. This credit can be used for: • Healthy foods • General supports for living (e.g., rent, mortgage, utilities) In order to qualify for SSBCI, members must have at least one of the following chronic health conditions: cardiovascular disorders, chronic and disabling mental health conditions, chronic gastrointestinal disease (limited to end stage liver disease), chronic lung disorders (limited to chronic obstructive pulmonary disorder), congestive heart failure, connective tissue disease, dementia, diabetes mellitus, overweight, obesity, & metabolic syndrome, and stroke. In addition: The condition must be life threatening or greatly limit overall health or function of the member; the member must be at high risk of hospitalization or other adverse health outcomes; and the member must require intensive care coordination. The plan will review objective criteria to determine a member's eligibility. For more information or to check eligibility, members should contact the plan.
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Additional Covered Benefits continued...

Telemedicine	\$0 copay We offer all members access 24 hours a day, 7 days a week, throughout the year to a participating doctor via telephone, desktop, or mobile device. Members can immediately have a medical, counseling, or psychiatry consultation with a physician. Members can also schedule a telemedicine appointment for a later time.
Worldwide Emergency/ Urgent Coverage	\$0 copay \$50,000 combined annual maximum plan benefit amount for worldwide emergency coverage, worldwide urgent coverage, and worldwide emergency transportation services.
24/7 Nurse Call Line	\$0 copay The 24/7 Nurse Call Line is a service available to all members 24 hours a day, seven days a week. The service is designed to provide members with a resource to answer health-related questions and to recommend the appropriate level of care.

Medicaid Services

Louisiana's Medicaid program covers many of the same things that private health insurance programs traditionally cover. Medicaid can also cover services to help "fill in the gaps" in Medicare and meet certain long-term care needs.

The list below includes things Louisiana Medicaid will cover in some or all cases. Some services are only offered to Medicaid recipients because of their age, family situation, transfer of resource requirements or other living arrangements. Also, some services are limited.

Before you receive a service, you should ask your doctor or provider about limits to receiving the service or if the service needs to be "prior authorized." ("Prior authorized" means Medicaid has to agree to pay for the service before it can be offered to a patient.)

Just because a service is not on the list does not mean that Medicaid will not cover it.

Benefits	<i>Access, Eligibility, What's covered and Notes</i>
Adult Denture Services	HOW TO ACCESS: Dentist ELIGIBILITY: Medicaid recipients 21 years of age and older. (Adults, 21 and over, certified as Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) only, PACE, Take Charge Plus or other programs with limited benefits are not eligible for dental services.) COVERED SERVICES: Examination, x-rays (are only covered if in conjunction with the construction of a Medicaid-authorized denture) dentures, denture relines, and denture repairs. Only one complete or partial denture per arch is allowed in an eight-year period. The partial denture must oppose a full denture. Two partials are not covered in the same oral cavity (mouth). Additional guidelines apply.

Adult Waiver Dental Services	HOW TO ACCESS: Dentist ELIGIBILITY: Medicaid recipients 21 years of age and older enrolled in New Opportunities Waiver, Residential Options Waiver or Supports Services Waiver. COVERED SERVICES: The Adult Waiver Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply.
Applied Behavioral Analysis (ABA)	Behavior analysis is based on a scientific study of how people learn. By doing research, techniques have been developed that increase useful behavior (including communication) and reduce harmful behavior. Applied behavior analysis (ABA) therapy uses these techniques. ABA is helpful in treating autism spectrum disorders. HOW TO ACCESS: Medicaid enrolled ABA provider. ELIGIBILITY: Age from birth up to 21 years of age; and COVERED SERVICES: ABA-based therapy services shall be rendered in accordance with the individual's approved treatment plan.
Behavioral Health – Adults	HOW TO ACCESS: Contact your health plan: AmeriHealth Caritas at 1(888) 756-0004 or visit online. ELIGIBILITY: Medicaid eligible adult. Adults eligible to receive mental health rehabilitation services under Medicaid State Plan include those who meet one of the following criteria: Must have a mental health diagnosis and Must be assessed by an LMHP Members receiving CPST and/or PSR:

Behavioral Health – Adults (cont.)	Must have at least a level of care of three on the LOCUS. Must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS). Members receiving IPS and PCS must be 21 years and older: Transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program. For more information, please refer to the BHS Provider Manual. COVERED SERVICES: 1. Community Psychiatric Support & Treatment (CPST) 2. Psychosocial Rehabilitation (PSR) 3. Crisis Intervention (CI) 4. Assertive Community Treatment (ACT) 5. Crisis Responses Services a. Mobile Crisis Response (MCR) b. Behavioral Health Crisis Care (BHCC) c. Community Based Crisis Service (CBCS) 6. Crisis Stabilization (CS) 7. Individual Placement and Supports (IPS) 8. Personal Care Services (PCS) 9. Peer Support Services (PSS) 10. Outpatient Therapy with Licensed Practitioners (medication management, individual, family, and group counseling) 11. Addiction Services (outpatient, residential, and inpatient) 12. Psychiatric Inpatient Hospital 18-21 years and over 65 years of age
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Chemotherapy	See Hospital-Outpatient Services; Physician/Professional Services HOW TO ACCESS: Hospital, Physician's office or clinic ELIGIBILITY: All Medicaid Recipients. COVERED SERVICES: Chemotherapy administration and treatment drugs, as prescribed by physician.
Chiropractic	HOW TO ACCESS: EPSDT Medical Screening Provider/PCP ELIGIBILITY: Medicaid recipients 0 through 20 years of age. COVERED SERVICES: Spinal manipulations.
Coordinated Systems of Care (CSoC) – Home and Community Based Services Waiver	HOW TO ACCESS: Magellan Health Services of Louisiana, 1-800-424-4489 ELIGIBILITY: Any child/youth experiencing a serious emotional disturbance who is at risk of out of home placement. A recipient must be under the age of 22 and meet the level of care or level of need through a Child and Adolescent Needs and Strengths (CANS) comprehensive assessment COVERED SERVICES: WRAP Around Planning, Parent Support & Training, Youth Support & Training, Independent Living/Skills Building, Short Term Respite Care, Crisis Stabilization, Case Conference, Treatment Planning

Durable Medical Equipment (DME)	HOW TO ACCESS: Physician ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Medical equipment and appliances such as wheelchairs, leg braces, etc. Medical supplies such as ostomy supplies, etc. Diapers and blue pads are only reimbursable as durable medical equipment items for Medicaid recipients 4 through 20 years of age.
EarlySteps (Infant & Toddler Early Intervention Services)	HOW TO ACCESS: Contact the Office for Citizens with Developmental Disabilities or call 1-866-783-5553. ELIGIBILITY: 1. Children ages birth to three who have a developmental delay of at least 1.5 SD (standard deviations) below the mean in two areas of development listed below: a. cognitive development b. physical development (including vision & hearing) c. communication development d. social or emotional development e. adaptive skills development (also known as self-help or daily living skills) 2. Children with a diagnosed medical condition with a high probability of resulting in developmental delay. COVERED SERVICES: Medicaid Covered Services Family Support Coordination (Service Coordination) Occupational Therapy Physical Therapy Speech/Language Therapy Psychology

EarlySteps (Infant & Toddler Early Intervention Services) (cont.)	Audiology Cognitive Development Physical Development (including vision and hearing) Communication Development Social or Emotional Development Adaptive Skills Development (also known as self-help or daily living skills) EarlySteps also provides the following services, not covered by Medicaid: Nursing Services/Health Services (Only to enable an eligible child/family to benefit from the other EarlySteps services). Medical Services for diagnostic and evaluation purposes only. Special Instruction Vision Services Assistive Technology devices and services Social Work Counseling Services/Family Training Transportation Nutrition Sign language and cued language services.
EPSDT Behavioral Health Services	HOW TO ACCESS: Contact your health plan: AmeriHealth Caritas at 1(888) 756-0004 or visit online. Medicaid eligible youth who meets the medical necessity criteria for behavioral health services as determined by a licensed mental health professional (LMHP) or physician. ELIGIBILITY: Meets medical necessity criteria for rehabilitation services for children under the age of 21. Children and youth eligible to receive mental health rehabilitation (MHR) services under Medicaid State Plan include those who meet one of the following criteria and is 21 years and older:

EPSDT Behavioral Health Services (cont.)	• Must be assessed by a licensed mental health professional. Members receiving CPST and/or PSR, ages 6 through 18 years of age, must be assessed using the CALOCUS. Members receiving CPST and/or PSR, ages 19 through 20 years of age, must be assessed using the LOCUS. Members who receive Multi-Systemic Therapy, Homebuilders, Functional Family Therapy and Functional Family Therapy-Child Welfare are not required to be assessed using the CALOCUS. COVERED SERVICES: 1. Community Psychiatric Support & Treatment (CPST) 2. Psychosocial Rehabilitation (PSR) 3. Crisis Intervention 4. Crisis Stabilization 5. Outpatient Therapy with Licensed Practitioners (medication management, individual, family, and group counseling) 6. Therapeutic Group Home 7. Psychiatric Residential Treatment Facility (PRTF) 8. Psychiatric Inpatient Hospital 9. Addiction Services (outpatient, residential, and inpatient) 10. Multi-systemic Therapy (MST) 11. Functional Family Therapy (FFT) 12. Homebuilders (HB) 13. Assertive Community Treatment (ACT) 14. Child Parent Psychotherapy (CPP) 15. Parent-child interaction therapy (PCIT) 16. Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT) 17. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
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EPSDT Behavioral Health Services (cont.)	18. Eye Movement Desensitization and Reprocessing (EMDR) Therapy 19. Coordinated System of Care (CSoC) (NOTE: Please see the CSoC section) 20. Mobile Crisis Response (MCR) 21. Community Brief Crisis Support (CBCS)
EPSDT Dental Services	HOW TO ACCESS: Dentist ELIGIBILITY: Medicaid recipients 0 through 20 years of age. COVERED SERVICES: The EPSDT Dental Program provides coverage of certain diagnostic; preventive; restorative; endodontic; periodontic; removable prosthodontic; maxillofacial prosthetic; oral and maxillofacial surgery; orthodontic; and adjunctive general services. Specific policy guidelines apply. Comprehensive Orthodontic Treatment (braces) are paid only when there is a cranio-facial deformity, such as cleft palate, cleft lip, or other medical conditions which possibly results in a handicapping malocclusion. If such a condition exists, the recipient should see a Medicaid-enrolled orthodontist. Patients having only crowded or crooked teeth, spacing problems or under/overbite are not covered for braces, unless identified as medically necessary.
EPSDT Personal Care Services	(See Long Term--Personal Care Services (LT-PCS) for Medicaid beneficiaries ages 65 or older, or age 21 or older with disabilities) Physician and Personal Care Attendant Agencies ELIGIBILITY: The person must be age birth through 20 years (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT-PCS by a practitioner (physician, advance practice nurse, or

EPSDT Personal Care Services (cont.)	physician assistant). The practitioner shall specify the health/medical condition that necessitates EPSDT-PCS. An EPSDT eligible shall meet medical necessity criteria which shall be based on functional and medical eligibility and impairment in at least two activities of daily living. To establish medical necessity, the EPSDT eligible must be of an age at which the tasks to be performed by the PCS provider would ordinarily be performed by the individual, if not for being disabled due to illness or injury. Children’s Choice waiver services and PCS may be performed on the same date, but not at the same time. If the beneficiary is receiving home health, respite, and/or any other related service, the PCS provider cannot provide service at the same time as the other Medicaid covered service provider. COVERED SERVICES: Basic personal care – toileting & grooming activities. Assistance with bladder and/or bowel requirements or problems. Assistance with eating and food preparation. Performance of incidental household chores, only for the beneficiary. Accompanying, not transporting, beneficiary to medical appointments. Does NOT cover any medical tasks such as medication administration, tube feedings, urinary catheters, ostomy or tracheostomy care.
EPSDT Screening Services	(Child Health preventive services) HOW TO ACCESS: Physician ELIGIBILITY: All Medicaid recipients 0 through 20 years of age. COVERED SERVICES: • A comprehensive health and developmental history (including assessment of physical and mental health and development)

EPSDT Screening Services (cont.)	• A comprehensive unclothed physical exam or assessment • Appropriate immunizations according to age and health history • Laboratory tests* (including age-appropriate screenings for newborns, iron deficiency anemia, blood lead levels, dyslipidemia, and sexually transmitted infections) • Health education (including anticipatory guidance) • Vision Screening • Hearing Screening • Dental Screening • Developmental Screening • Autism Screening • Perinatal Depression Screening
Family Planning Services – Take Charge Plus	HOW TO ACCESS: Any Medicaid provider who offers family planning services. For assistance with locating a provider, click here. ELIGIBILITY: All Louisiana residents of childbearing age regardless of gender with an income at or below 138% of the Federal Poverty level. Pregnant women are excluded from this program. COVERED SERVICES: Family planning related services and care related to: • Birth control (pills, implants, injections, condoms, and IUDs) • Cervical cancer screening and treatment for most abnormal results • Contraceptive counseling and education • Prescriptions, and follow-up visits to treat STIs • Treatment of major complications from certain family planning procedures • Voluntary sterilization for males and females (over age 21)

Family Planning Services – Take Charge Plus (cont.)	• Vaccines for both males and females for the prevention of HPV • Transportation to family planning appointments
Family Planning Services in Physician’s Office	HOW TO ACCESS: Physician or Healthcare Professional ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists, physician assistant. Certain family planning services are covered when provided in a physician's office.
Federally Qualified Health Centers (FQHC)	HOW TO ACCESS: Nearest FQHC The American Indian Clinic ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists.
Free Standing Birthing Centers	HOW TO ACCESS: Certified Nurse Midwife or Licensed Midwife ELIGIBILITY: All Medicaid eligible pregnant women. COVERED SERVICES: Vaginal delivery services for females who have had a low risk, normal pregnancy, prenatal care and that are expected to have an uncomplicated labor and normal vaginal delivery.

Hearing Aids	See Durable Medical Equipment HOW TO ACCESS: Durable Medical Equipment Provider ELIGIBILITY: Medicaid recipients 0 to 20 years of age. COVERED SERVICES: Hearing Aids and any related ancillary equipment such as earpieces, batteries, etc. Repairs are covered if the Hearing Aid was paid for by Medicaid.
Hemodialysis Services	See Hospital-Outpatient Services HOW TO ACCESS: Dialysis Centers Hospitals ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Dialysis treatment (including routine laboratory services); medically necessary non-routine lab services; and medically necessary injections.
Home Health	Home Health Basic HOW TO ACCESS: A physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with State law. This is referred to as an Authorized Healthcare Provider. ELIGIBILITY: All Medicaid recipients. Medically Needy (Type Case 20 & 21) recipients are not eligible for Aide Visits, Physical Therapy, Occupational Therapy, Speech/Language Therapy.

Home Health (cont.)	COVERED SERVICES: • Intermittent/part-time nursing services including skilled nurse visits. • Aide Visits. • Physical Therapy Services • Occupational Therapy • Speech/Language Therapy Home Health Extended HOW TO ACCESS: A physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with State law. This is referred to as an Authorized Healthcare Provider. ELIGIBILITY: Medicaid recipients 0 to 20 years of age. COVERED SERVICES: Multiple hours of skilled nurse services. All medically necessary medical tasks that are part of the plan of care can be administered in the home. Home Health: Crisis Response Team ELIGIBILITY: Medicaid recipients 0 to 20 years of age that are under the following waiver programs AND Who are not receiving some or all the hours of extended home health or intermittent nursing services as authorized by the program requirements. WAIVER PROGRAMS: • Children's Choice Waiver (CCW) • New Opportunities Waiver (NOW) • Supports Waiver (SW) • Residential Options Waiver (ROW)
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Hospice	HOW TO ACCESS: Hospice Provider/Physician ELIGIBILITY: All Medicaid recipients. Hospice eligibility information: 1-800-877-0666, Option 2 COVERED SERVICES: Medicare allowable services.
Hospital	Inpatient and Outpatient Services, including Emergency Room Services HOW TO ACCESS SERVICES: Physician/Hospital Eligibility: All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient Psychiatric Services. COVERED SERVICES: Inpatient and Outpatient Hospital Services, including Emergency Room Services
Hospital – Emergency Room Services	Inpatient and Outpatient Services, including Emergency Room Services HOW TO ACCESS SERVICES: Physician/Hospital Eligibility: All Medicaid recipients. COVERED SERVICES: Emergency Room Services
Hospital – Inpatient Services	Hospital-Inpatient Services HOW TO ACCESS: Physician/Hospital ELIGIBILITY: All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient Psychiatric Services.

Hospital – Inpatient Services (cont.)	COVERED SERVICES: Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely & adequately in a hospital setting. Includes those basic services that a hospital is expected to provide.
Hospital- Outpatient Services	HOW TO ACCESS: Physician/Hospital ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: • Diagnostic & therapeutic outpatient services, including outpatient surgery and rehabilitation services. • Therapeutic and diagnostic radiology services. • Chemotherapy • Hemodialysis
Laboratory Tests & Radiology Services	HOW TO ACCESS: Physician ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Most diagnostic testing and radiological services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.
Long Term – Personal Care Services (LT-PCS)	(See EPSDT Personal Care Services - for children ages 0 to 21) HOW TO ACCESS: Louisiana Options in Long-Term Care 1-877-456-1146

Long Term – Personal Care Services (LT-PCS) (cont.)	ELIGIBILITY: All Medicaid recipients aged 65 or older, or age 21 with disabilities (meets Social Security Administration disability criteria), must meet the medical standards for admission to a nursing facility and additional targeting criteria, and be able to participate in his/her care and direct the services provided by the worker independently or through a responsible representative. Applicants must require at least limited assistance with at least one Activity of Daily Living. COVERED SERVICES: • Basic personal care-toileting & grooming activities. • Assistance with bladder and/or bowel requirements or problems. • Assistance with eating and food preparation. • Performance of incidental household chores, only for the recipient. • Accompanying, not transporting, recipient to medical appointments. • Grocery shopping, including personal hygiene items.
Nursing Facility	HOW TO ACCESS: Office of Aging and Adult Services (OAAS) Contact: Louisiana Options in Long Term Care (Conduent), 1-877-456-1146 ELIGIBILITY: Medicaid recipients and persons who would meet Medicaid Long Term Care financial eligibility requirements and who meet nursing facility level of care as determined by OAAS. COVERED SERVICES: Skilled Nursing or medical care and related services; rehabilitation needed due to injury, disability, or illness; health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Optical Services	HOW TO ACCESS: Optometrist, Ophthalmologist or Optical Supplier ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Recipients 0 through 20 Examinations and treatment of eye conditions, including examinations for vision correction, refraction error. Regular eyeglasses when they meet a certain minimum strength requirement. Medically necessary specialty eyewear and contact lenses with prior authorization. Contact lenses are covered if they are the only means for restoring vision. Other related services, if medically necessary. Recipients 21 and over Examinations and treatment of eye conditions, such as infections, cataracts, etc. If the recipient has both Medicare and Medicaid, some vision related services may be covered. The recipient should contact Medicare for more information since Medicare would be the primary payer.
Pediatric Day Health Care (PDHC)	HOW TO ACCESS: Physician or PDHC Agencies ELIGIBILITY: Medicaid recipients 0 through 20 who have a medically fragile condition and who require nursing supervision and possibly therapeutic interventions all or part of the day due to a medically complex condition. COVERED SERVICES: Nursing care, Respiratory care, Physical Therapy, Speech-language therapy, Occupational Therapy, Social Services, personal care services and transportation to and from PDHC facility.

PACE – Program for All Inclusive Care for the Elderly	*Program available in Greater New Orleans, Baton Rouge, and Lafayette area. HOW TO ACCESS: Office of Aging and Adult Services (OAAS) Contact: PACE GNO at (504) 945-1531 Franciscan PACE Baton Rouge at (225) 490-0604 Franciscan PACE Lafayette at (337) 470-4500 Trinity Health Alexandria at (318) 206-1020 ELIGIBILITY: Participants are persons aged 55 years or older, live in the PACE provider service area and are certified to meet nursing facility level of care and financially eligible for Medicaid long term care. Participation is voluntary and enrollees may disenroll at any time. COVERED SERVICES: ALL Medicaid and Medicare services, both acute and long-term care
Pharmacy Services	HOW TO ACCESS: Pharmacies ELIGIBILITY: All Medicaid recipients except some who are Medicare/Medicaid eligible. Recipients who are full benefit dual eligible (Medicare/Medicaid) received their pharmacy benefits through Medicare Part D. Recipients enrolled with an MCO; with only behavioral health services, receive prescription benefits through the fee-for-service Medicaid program. COVERED SERVICES: Covers prescription drugs, except: • Cosmetic drugs (Except Accutane). • Cough & cold preparations. • Anorexics (Except for Xenical). • Fertility drugs when used for fertility treatment. • Experimental drugs. • Compounded prescriptions.

Pharmacy Services (cont.)	• Drug Efficacy Study Implementation (DESI) drugs. • Erectile Dysfunction (ED) Medications • Over the counter (OTC) drugs, with some exceptions. COMMENTS: Co-payments (\$0.50-\$3.00) are required except for some recipient categories. Prescription limits: 4 per calendar month (The physician can approve an override for this limit when medically necessary). Limits do not apply to recipients under age 21, pregnant women, or those in Long Term Care. Prior Authorization is required for some drugs.
Physician/Professional Services	HOW TO ACCESS: Physician or Healthcare Professional ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Professional medical services including those of a physician, nurse midwife, nurse practitioner, clinical nurse specialists, physician assistant. Certain family planning services are covered when provided in a physician's office.
Podiatry Services	HOW TO ACCESS: Podiatrist ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Office visits. Certain radiology & lab procedures and other diagnostic procedures.
Pre-Natal Care	HOW TO ACCESS: Physicians or Healthcare Professional ELIGIBILITY: Female Medicaid recipients of childbearing age. COVERED SERVICES: Office visits. Lab and radiology services.

Psychiatric Hospital Care	HOW TO ACCESS: Physician/Hospital ELIGIBILITY: All Medicaid recipients. Medically Needy (Type Case 20 & 21) under age 22 are not eligible for Inpatient Psychiatric Services. COVERED SERVICES: Inpatient hospital care needed for the treatment of an illness or injury which can only be provided safely & adequately in a hospital setting. Includes those basic services that a hospital is expected to provide.
Rehabilitation Clinic Services	HOW TO ACCESS: Physician ELIGIBILITY: Medicaid recipients 0 through 20 years of age COVERED SERVICES: Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy
Rural Health Clinics	HOW TO ACCESS: Rural Health Clinic, The American Indian Clinic ELIGIBILITY: All Medicaid recipients COVERED SERVICES: Professional medical services furnished by physicians, nurse practitioners, physician assistants, nurse midwives, clinical social workers, clinical psychologists, and dentists.
STD Clinics	HOW TO ACCESS: OPH Public Health Units ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Testing, counseling, and treatment of all sexually transmitted diseases (STD). Confidential HIV testing.
Therapy Services	HOW TO ACCESS: Recipients have the choice of services from the following provider types: Home Health;

Therapy Services (cont.)	Hospital-Outpatient Services; and Rehabilitation Clinic Services. ELIGIBILITY: Medicaid recipients 0 through 20 years of age. COVERED SERVICES: • Audiological Services (Available in Rehabilitation Clinic and Hospital-Outpatient settings only.) • Occupational Therapy • Physical Therapy • Speech & Language Therapy HOW TO ACCESS: EPSDT Health Services-Early Intervention Centers (EIC) or EarlySteps Program ELIGIBILITY: Medicaid recipients under 3 years of age. COVERED SERVICES: • Audiological Services • Occupational Therapy • Physical Therapy • Speech & Language Therapy • Psychological Therapy HOW TO ACCESS: EPSDT Health Services-Local Education Agencies (LEA) e.g. School Boards ELIGIBILITY: Medicaid recipients 3 through 20 years of age. COVERED SERVICES: • Behavioral Health Services • Applied Behavior Analyst Therapy (ABA) • Occupational, Physical, Speech and Respiratory Therapy • Optometry Services • Personal Care Services (PCS) • Physician/Nursing Services • Transportation
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Transportation	Non-Emergency Medical Transportation HOW TO ACCESS: All Medicaid beneficiaries, who are eligible for transportation services and DO NOT receive transportation services through a managed care plan, should contact Verida to schedule a ride. Beneficiaries may reach the Fee-For-Service broker, Verida, at 1 (855)325-7626. Medicaid beneficiaries who DO receive transportation services from a managed care plan should contact the call centers as follows: AmeriHealth Caritas uses Verida, contact them at 1(888) 913-0364 or TTY 1(866)428-7588. ELIGIBILITY: Medicaid covered transportation is available to Medicaid beneficiaries when: The beneficiary is enrolled in a Medicaid benefit program that explicitly includes transportation services; and The beneficiary or their representative has stated that they have no other means of transportation. COVERED SERVICES: Transportation to and/or from Medicaid covered services, including carved-out services, or value-added benefits (VAB) when no other means of transportation is available. Beginning January 1, 2023, Medicaid will only reimburse for a beneficiary's transportation services to a Fee-For-Service (FFS) provider or a managed care provider if that provider has enrolled through the Medicaid Provider Enrollment. LDH granted all NEMT providers an extension for enrollment in the Medicaid Provider Portal. All NEMT providers were required to enroll in the Medicaid Provider Portal no later than June 30, 2023.
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Transportation (cont.)	Attendants An attendant shall be required when the beneficiary is under the age of 17. The attendant must: Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and Be able to authorize medical treatment and care for the beneficiary. Attendants may not: Be under the age of 17; or Be a Medicaid provider or employee of a Medicaid provider that is providing services to the beneficiary being transported, except for employees of a mental health facility in the event an beneficiary has been identified as being a danger to themselves or others or at risk for elopement. Be a transportation provider or an employee of a transportation provider. If a child is to be transported, either as the beneficiary or an additional passenger, the parent or guardian of the child is responsible for providing an appropriate child passenger restraint system as outlined by La. R.S. 32:295. Meals and Lodging: Eligible expenses include the following when necessary to ensure the delivery of medically necessary services: Transportation for the beneficiary and one attendant; and Meals, lodging, and other related travel expenses for the beneficiary and one attendant when long distance travel is required. Long distance is defined as when the total travel time, including the duration of the appointment plus the travel to and from the appointment, exceeds 12 hours Medicaid covers meals and lodging for trips that are not otherwise covered in the inpatient per diem, primary insurance, or other payer source.
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Transportation (cont.)	HOW TO ACCESS: All Medicaid beneficiaries, who are eligible for transportation services and DO NOT receive transportation services through a managed care plan, should contact Verida to schedule a ride. Beneficiaries may reach the Fee-For-Service broker, Verida, at (225) 726-2800. Medicaid beneficiaries who DO receive transportation services from a managed care plan should contact the call centers as follows: AmeriHealth Caritas at (225) 726-2800, via email, or via fax at (337) 225-448-2017. ELIGIBILITY: Medicaid covered transportation is available to Medicaid beneficiaries when: The beneficiary is enrolled in a Medicaid benefit program that explicitly includes transportation services; and The beneficiary or their representative has stated that they have no other means of transportation. GROUND AMBULANCE COVERED SERVICES: NEAT is provided to a Medicaid beneficiary to and/or from a Medicaid covered service, including carved out services or value-added benefits (VAB) by ground or air ambulance when the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury. The nature of the trip is not an emergency, but the beneficiary requires the use of an ambulance. Beginning January 1, 2023, Medicaid will only reimburse for a beneficiary's transportation services to a FFS provider or a managed care provider if that provider has enrolled through the Medicaid Provider Enrollment. All ambulance providers are required to enroll in the Medicaid Provider Portal no later than December 31, 2022. Please note that ALL NEAT trips will require a completed, valid Certification of Ambulance
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Transportation (cont.)	Transportation (CAT). The beneficiary's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition, which necessitates ambulance services. The MCO, transportation broker, and/or the ambulance provider shall verify, prior to scheduling, beneficiary eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the MCO, transportation broker, and/or the ambulance provider prior to transport. Attendants An attendant shall be required when the beneficiary is under the age of 17. The attendant must: Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and Be able to authorize medical treatment and care for the beneficiary. Attendants may not: Be under the age of 17; or Be a Medicaid provider or employee of a Medicaid provider that is providing services to the beneficiary being transported, except for employees of a mental health facility in the event an beneficiary has been identified as being a danger to themselves or others or at risk for elopement. Comments: Medicaid beneficiaries should contact the broker's call centers at least 48 hours prior to the requested transportation services.
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Transportation (cont.)	With the exception of urgent transportation requests and discharges from inpatient facilities, when requesting transportation services, the beneficiary's and healthcare providers should schedule all services a minimum of 48 hours prior to the requested appointment. The 48-hour minimum does not include non-business days. However, the MCO and/or transportation broker must make a reasonable attempt to schedule the trip with less than 48 hours' notice. MCOs shall make every effort to schedule urgent transportation requests and may not deny a request based solely on the appointment being scheduled less than 48 hours in advance. Urgent transportation refers to a request for transportation made by a healthcare provider for a medical service, which does not warrant emergency transport but cannot be postponed. Urgent transportation shall include chemotherapy, radiation, dialysis, OTP, or other necessary medical care that cannot be rescheduled to a later time. All non-emergency out-of-state transportation must be prior approved by the MCO or transportation broker. The MCO may approve transportation to out-of-state medical care only if the beneficiary has been granted approval to receive medical treatment out of state when it is the nearest option available. Coordination of approvals may take longer than 48 hours. Nursing Facility Ambulance Transportation Nursing facilities are required to provide medically necessary transportation services for Medicaid beneficiary residing in their facilities. Any nursing facility beneficiary needing non-emergency, non-ambulance transportation services are the financial
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Transportation (cont.)	responsibility of the nursing facility. NEAT services provided to a nursing facility beneficiary must include the Certification of Ambulance Transportation, in accordance with the Coverage Requirements section, to be reimbursable by the MCO and/or transportation broker; otherwise, the nursing facility shall be responsible for reimbursement for such services. Air Ambulance: Air ambulances may be used for emergency and non-emergency ambulance transportation when medically necessary. All air ambulance services must comply with state laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians, and pilots as administered by the appropriate agency of competent jurisdiction. The MCO shall cover air ambulance services only if: Speedy admission of the beneficiary is essential and the point of pick-up of the beneficiary is inaccessible by a land vehicle; or Great distances or other obstacles are involved in getting the beneficiary to the nearest hospital with appropriate services. If both land and air ambulance transport are necessary during the same trip, the MCO shall reimburse each type of provider separately according to regulations for that type of provider. The MCO and/or transportation broker may not require prior review or authorization for emergency air ambulance transportation, both rotary and fixed wing. The MCO and/or transportation broker may require prior review or authorization for non-emergency air ambulance transportation, both rotary and fixed wing.
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Transportation (cont.)	Emergency Ambulance Transportation (EMT) HOW TO ACCESS: Emergency ambulance providers, Dial 911 for all situations requiring emergency medical services. ELIGIBILITY: Medicaid covered transportation is available to Medicaid beneficiaries when: The beneficiary is enrolled in a Medicaid benefit program that explicitly includes emergency transportation services COVERED SERVICES: Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: Placing the health of the beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; Serious impairment to bodily functions; or Serious dysfunction of any bodily organ or part. A beneficiary may also require emergency ambulance transportation if he or she is psychiatrically unmanageable or needs restraint. Beginning January 1, 2023, Medicaid will only reimburse for a beneficiary's transportation services to a FFS provider and/or managed care provider if that provider has enrolled through the Medicaid Provider Enrollment Portal
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Tuberculosis Clinics	HOW TO ACCESS: Office of Public Health Local Health Unit ELIGIBILITY: All Medicaid recipients COVERED SERVICES: Treatment and disease management services including physician visits, medications, and x-rays.
X-Ray Services	HOW TO ACCESS: Physician ELIGIBILITY: All Medicaid recipients. COVERED SERVICES: Most diagnostic testing and radiological services ordered by the attending or consulting physician. Portable (mobile) x-rays are covered only for recipients who are unable to leave their place of residence without special transportation or assistance to obtain physician ordered x-rays.

Support Coordination

Children's Choice Waiver	ELIGIBILITY: Medicaid recipients must be in the Children's Choice Waiver. There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the RFSR, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section.
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Community Choice Waiver	HOW TO ACCESS: Office of Aging and Adult Services (OAAS) 1-866-758-5035, Participants call, 1-866-758-5035 or 225-219-0643 ELIGIBILITY: Medicaid recipients must be in the Community Choices Waiver (CCW). There is a Request for Services Registry (RFSR) for those requesting CCW waiver services. Contact Louisiana Options in Long Term Care at 1-877-456-1146. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.
EPSDT Targeted Populations	HOW TO ACCESS: SRI Call Toll-Free 1-800-364-7828, Must be on the DD Request for Services Registry ELIGIBILITY: Must be Medicaid eligible and on the DD waiver Request for Services Registry prior to receipt of case management services; or any Medicaid recipient 3 through 20 years of age for whom support coordination is medically necessary (Call SRI at 1-800-364-7828). To get on the Request for Services Registry, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.

Infants and Toddlers	HOW TO ACCESS: Office for Citizens with Developmental Disabilities (OCDD) 1-866-783-5553 ELIGIBILITY: Medicaid recipients must be 0 to 3 years of age and have a developmental delay or an established medical condition and eligible for the EarlySteps system. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care in EarlySteps.
New Opportunities Waiver (NOW)	ELIGIBILITY: Medicaid beneficiaries must be in the New Opportunities Waiver. There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the RFSR, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section.
Residential Options Waiver (ROW)	ELIGIBILITY: Medicaid beneficiaries must be in the Residential Options Waiver. There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the RFSR, call the Office for Citizens with Developmental Disabilities District/Authority Local Regional Office. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care.

Supports Waiver	ELIGIBILITY: Medicaid beneficiaries must be in the Supports Waiver. There is a Request for Services Registry (RFSR) for those requesting waiver services. To get on the RFSR, call the Office for Citizens with Developmental Disabilities District/Authority/Local Regional Office. COVERED SERVICES: Coordination of Medicaid and other services. The Support Coordinator (Case Manager) helps to identify needs, access services and coordinate care. Services available through the Waiver are identified in the waiver section.
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Waiver Services

Children's Choice	HOW TO ACCESS: Individuals who have a need for services should contact their Local Governing Entity (LGE) to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR). Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with emergent and urgent need for support will have priority. For more information on this process, please contact your local Human Services District/Authority ELIGIBILITY: Meet Louisiana Medicaid eligibility AND Meet the Louisiana definition for developmental disability which manifested prior to the age of 22 (Revised Statute 28:451.2, Paragraph (11)) AND
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Children's Choice (cont.)	Have an OCDD Statement of Approval AND Meet My Place eligibility if age 0-3 AND Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria AND Are 0 through 20 years of age. COVERED SERVICES: • Support Coordination • Family Support • Crisis Support • Center-Based Respite • Family Training • Environmental Accessibility Adaptations • Specialized Medical Equipment • Permanent Supportive housing Stabilization and Transition • Therapy services: Aquatic Therapy, Art Therapy, Music Therapy, Hippo-Therapy/Therapeutic Horseback Riding, Sensory Integration • Financial Management Services for Self-Direction • *Individuals under the age of 21 years of age must access Early and Periodic Screening, Diagnostic and Treatment Personal Care Services (EPSDT-PCS).
New Opportunities Waiver	HOW TO ACCESS: Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR). Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with emergent and urgent need for support will have priority.

New Opportunities Waiver (cont.)	For more information on this process, please contact your local Human Services District/Authority. ELIGIBILITY: Meet Louisiana Medicaid eligibility AND Meet the Louisiana definition for developmental disability which manifested prior to the age of 22 (Revised Statute 28:451.2, Paragraph (11)) AND Have an OCDD Statement of Approval AND Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria AND Are 3 years of age or older AND Whose needs cannot be met in another OCDD Waiver. COVERED SERVICES: • Individual and Family Support (IFS) for Day, Night, Shared • Center-Based Respite • Community Life Engagement Development • Environmental Accessibility Adaptations • Specialized Medical Equipment and Supplies • Supported Independent Living • Substitute Family Care • Day Habilitation/Community Life Engagement and Transportation • Supported Employment (individual or group) and Transportation • Skilled Nursing • Prevocational/Community Career Planning and Transportation • Personal Emergency Response System (PERS) • Permanent Supportive housing Stabilization and Transition • One time transitional services • Monitored In Home Care Giving (MIHC) • Adult Companion Care • Professional Services • Expanded Dental Services for Adult Waiver Beneficiaries • Financial Management Services for Self-Direction
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New Opportunities Waiver (cont.)	*Individuals under the age of 21 years of age must access Early and Periodic Screening, Diagnostic and Treatment Personal Care Services (EPSDT-PCS). *Individuals will receive Support Coordination services via state plan.
Residential Options Waiver (ROW)	HOW TO ACCESS: Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR). Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with emergent and urgent need for support will have priority. For more information on this process, please contact your local Human Services District/Authority. ELIGIBILITY: Meet Louisiana Medicaid eligibility AND Meet the Louisiana definition for developmental disability which manifested prior to the age of 22 (Revised Statute 28:451.2, Paragraph (12)) AND Have an OCDD Statement of Approval AND Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria AND Meet one of four ROW priority group criteria. COVERED SERVICES: • Support Coordination • Community Living Supports • Host Home Services • Companion Care Services • Shared Living • Adult Day Health Care

Residential Options Waiver (ROW) (cont.)	• Respite-Out of Home • Personal Emergency Response System (PERS) • One Time Transitional Services • Environmental Accessibility Adaptations • Monitored In Home Caregiving (MIHC) • Specialized Medical Equipment and Supplies • Community Life Engagement Development • Professional Services • Nursing Services • Supported Employment (Individual or group) and transportation • Prevocational/Community Career Planning and Transportation • Day Habilitation/Community Life Engagement and Transportation • Permanent Supportive housing Stabilization and Transition • Expanded Dental Services for Adult Waiver Beneficiaries • Financial Management Services for Self-Direction • *Individuals under the age of 21 years of age must access Early and Periodic Screening, Diagnostic and Treatment Personal Care Services (EPSDT-PCS).
Supports Waiver	HOW TO ACCESS: Individuals who have a need for services should contact their Local Governing Entity (LGE) in order to go through the eligibility determination process. Once a person is eligible for OCDD services, they may ask to be placed on the Developmental Disability Request for Services Registry (RFSR). Home and community-based waiver opportunities are provided based on the individual's prioritized need for support, which is identified in their RFSR Screening for Urgency of Need. Individuals with emergent and urgent need for support will have priority. For more information on this process, please contact your local Human Services District/Authority.

Supports Waiver (cont.)	ELIGIBILITY: Meet Louisiana Medicaid eligibility AND Meet the Louisiana definition for developmental disability which manifested prior to the age of 22 (Revised Statute 28:451.2, Paragraph (11)) AND Have an OCDD Statement of Approval AND Meet Intermediate Care Facility-Intellectual Disability (ICF-ID) Level of Care Criteria AND Are 18 years of age or older. COVERED SERVICES: • Support Coordination • Supported Employment (individual or group) and transportation • Day Habilitation/Community Life Engagement and Transportation • Prevocational/Community Career Planning and transportation • Habilitation • Respite (center-based or in home) • Permanent Supportive Housing Stabilization and Transition • Personal Emergency Response System (PERS) • Expanded Dental Services for Adult Waiver Beneficiaries • Community Life Engagement Development • Specialized Medical Equipment and Supplies • *Individuals who are 18-21 years of age may access Early Periodic Screening, Diagnostic and Treatment Personal Care Services (EPSDT-PCS). • *Individuals 21 years of age or older who receive SW may also receive Long Term-Personal Care Services (LT-PCS).
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For more information, please contact AmeriHealth Caritas VIP Care:

- **Not a member yet?**
Contact us at 1-800-464-3829 (TTY 711), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week. From April 1 - September 30, call 8 a.m. - 8 p.m., Monday through Friday.
- **Already a member?**
Contact us at 1-833-852-4433 (TTY 711), October 1 - March 31, 8 a.m. - 8 p.m., seven days a week. From April 1 - September 30, call 8 a.m. - 8 p.m., Monday through Friday.
- Visit our website at www.amerihealthcaritasvipcare.com/la.

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), 24 hours a day, seven days a week.

This information is not a complete description of benefits. Call 1-833-852-4433 (TTY 711) at the hours listed above for more information.

AmeriHealth Caritas VIP Care is an HMO-DSNP plan with a Medicare contract and a contract with the Louisiana Medicaid program. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-833-852-4433 (TTY 711), October 1 – March 31, 8 a.m. – 8 p.m., seven days a week. From April 1 – September 30, call 8 a.m. – 8 p.m., Monday through Friday. The call is free.

125025 (7/25)



www.amerihealthcaritasvipcare.com/la

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