PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
1A	Inpatient Hospital - Acute	Additional Days	Required	**Is the Benefit unlimited?** Yes If No: Indicate Number of additional days per period: <u>Coinsurance</u> **Number of day intervals for Additional Days:** Zero (no coinsurance per day) **Coinsurance % and intervals:** % Interval 1: / Begin Day Interval 1: / End Day Interval 1: % Interval 2: / Begin Day Interval 2: / End Day Interval 2: % Interval 3: / Begin Day Interval 3: / End Day Interval 3: <u>Copayment</u> **Number of day intervals for Additional Days:** Zero (no coinsurance per day) **Copayment amounts and intervals:** Amt Interval 1: / Begin Day Interval 1: / End Day Interval 1: Amt Interval 2: / Begin Day Interval 2: / End Day Interval 2: Amt Interval 3: / Begin Day Interval 3: / End Day Interval 3: **Authorization from:** Procedures generally accepted by the medical community and which are medically necessary may not require prior approval. **Referral required? No**	Elective medical and surgical treatments (except family planning services and medically necessary cosmetic surgery), are excluded from payment unless prior approved by the Health Plan or its authorized agent. Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from payment. Procedures, counseling, and testing for the inducement of fertility are excluded from payment. Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Health Plan or its authorized agent. IDAPA 16.03.09.400-406
		Non-Medicare Covered Stay	Required	**Is the coinsurance structure the same as the Medicare-covered stay?** No; no coinsurance. If No (1): Coinsurance Percentage: If No (2): Number of day intervals: Zero (no coinsurance per day)/One/Two/Three If No (3): Coinsurance % and intervals: % Interval 1: / Begin Day Interval 1: / End Day Interval 1: % Interval 2: / Begin Day Interval 2: / End Day Interval 2: % Interval 3: / Begin Day Interval 3: / End Day Interval 3: **Is the copayment structure the same as the Medicare-covered stay?** Yes (no copayment) If No (1): Co-payment amount for non-Medicare stay If No (2): Number of day intervals: If No (3): : Amt Interval 1: / Begin Day Interval 1: / End Day Interval 1: Amt Interval 2: / Begin Day Interval 2: / End Day Interval 2: Amt Interval 3: / Begin Day Interval 3: / End Day Interval 3: **Authorization from:** Procedures generally accepted by the medical community and which are medically necessary may not require prior approval. **Referral required?** No	

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Upgrades	Not Required		
1B	Inpatient Hospital Psychiatric	Additional Days	Not Required		IDAPA 16.03.09.702-706 and 16.03.10.100-102
		Non-Medicare Covered Stay	Required	Is the Benefit unlimited? Yes **Copayment:** None **Authorization from:** PCP **Referral required?** Yes	

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
2	Skilled Nursing Facility	Additional Days beyond Medicare-covered	Required	**Is the Benefit unlimited?** Yes If No: Indicate Number of additional days per period: Patient Liability **Number of day intervals for Additional Days:** One Patient Liability **and intervals:Members in long-term care facilities may be required to pay a patient liability for the cost of the long-term care services to the long-term care facilities in accordance with IDAPA 16.03.10.224 and 16.03.05.722-726.** % Interval 1: / Begin Day Interval 1: / End Day Interval 1: % Interval 2: / Begin Day Interval 2: / End Day Interval 2: % Interval 3: / Begin Day Interval 3: / End Day Interval 3: <u>Copayment</u> Number of day intervals for Additional Days: Zero (no copayment per day) Copayment amounts and intervals: Amt Interval 1: / Begin Day Interval 1: / End Day Interval 1: Amt Interval 2: / Begin Day Interval 2: / End Day Interval 2: Amt Interval 3: / Begin Day Interval 3: / End Day Interval 3: Authorization from: Prior authorization is initiated by the Medical Home Referral required? Yes	IDAPA 16.03.10.220-296
		Non-Medicare Covered Stay	Required	**Is the Benefit unlimited?** Yes If No: Indicate Number of additional days per period: Patient Liability **Number of day intervals for Additional Days:** One Patient liability **% and intervals:**Members in long-term care facilities may be required to pay a monthly patient liability for the cost of the long-term care services to the long-term care facilities in accordance with IDAPA 16.03.10.224 and 16.03.05.722-726. % Interval 1: / Begin Day Interval 1: / End Day Interval 1: % Interval 2: / Begin Day Interval 2: / End Day Interval 2: % Interval 3: / Begin Day Interval 3: / End Day Interval 3: <u>Copayment</u> Number of day intervals for Additional Days: Zero (no copayment per day) Copayment amounts and intervals: Amt Interval 1: / Begin Day Interval 1: / End Day Interval 1: Amt Interval 2: / Begin Day Interval 2: / End Day Interval 2: Amt Interval 3: / Begin Day Interval 3: / End Day Interval 3: Authorization from: Prior authorization is initiated by the Medical Home Referral required? Yes	

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Less than 3 day inpatient hospital stay prior to SNF admission	Required	**Do you allow less than 3 day inpatient hospital stay prior to SNF admission:** Yes If Yes: Indicate number of days required: Zero	
3	Cardiac and Pulmonary Rehabilitation Services	Additional Cardiac Rehabilitation Services	Not Required		
		Additional Intensive Cardiac Rehabilitation Services	Not Required		
		Additional Pulmonary Rehabilitation Services	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
4C	Emergency Care	Worldwide Coverage	Not Required		
6	Home Health Services	Additional Hours of Care	Required	**Max Benefit Coverage:** Yes If Yes: Max Coverage Amount: Home health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, home health speech-language pathologist, or licensed nurse. If Yes: Max Coverage Periodicity: Yearly **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Home health services are ordered by a physician. **Referral required?** Yes	IDAPA 16.03.09.720-725

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Personal Care Services	Not Required		
		Other 1: Provide Label:			
		Other 2: Provide Label:			

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
7B	Chiropractic Services	Routine Care	Required	**Unlimited Benefit:** No If No (1): Number of routine care visits: Six (6) If No (2): Routine care periodicity: Yearly **Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: Six (6) office visits If Yes (2): Max Coverage Periodicity: Yearly **Enrollee MOOP:** No If Yes (1): MOOP Amount: If Yes (1): MOOP Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: $3.65 (see IDAPA 16.03.18.310-330) If Yes (2): Copayment Maximum: $3.65 (see IDAPA 16.03.18.310-330) **Authorization from:** None **Referral required?** No	Only treatment involving manipulation of the spine to correct a subluxation condition is covered. IDAPA 16.03.09.530-532
7C	Occupational Therapy Services	Non-Medicare Occupational Therapy Service: Plan to provide label	Not Required		Although Medicaid does not supplement Medicare occupational therapy benefits, enrollees with developmental disabilities approved for 1915(i) and 1915(c) services have the following limitations: The combination of adult day care, developmental therapy and occupational therapy must not exceed thirty (30) hours per week; and therapy services (psychotherapy, physical therapy, occupational therapy and speech-language pathology services) provided in combination with community supported employment services must not exceed forty (40) hours per week.

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
7F	Podiatry Services	Routine Foot Care	Required	**Unlimited Benefit: Yes** If No (1): Number of routine foot care visits: If No (2): Routine foot care periodicity: **Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	Coverage for podiatrist services is limited to: 1. Services Defined in chronic care guidelines . Acute and preventive foot care services defined in chronic care guidelines; and 2. Treatment of Acute Conditions. Treatment of acute conditions that if left untreated will result in chronic damage to the participant's foot. IDAPA 16.03.09.540-544. For guidance see https://www.idmedicaid.com/Provider%20Guidelines/Podiatric%20Medicine%20and%20Surgery%20Services.pdf
7I	Physical Therapy and Speech Language Pathology Services	Other 1: Provide label	Not Required		Although Medicaid does not supplement Medicare occupational therapy benefits, enrollees with developmental disabilities approved for 1915(i) and 1915(c) services have the following limitations: The combination of adult day care, developmental therapy and occupational therapy must not exceed thirty (30) hours per week; and therapy services (psychotherapy, physical therapy, occupational therapy and speech-language pathology services) provided in combination with community supported employment services must not exceed forty (40) hours per week.
		Other 2: Provide label	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
9D	Outpatient Blood Services	Three-pint deductible waived	Not Required		
10B	Transportation Services	Plan-approved location	Required	**Is the Benefit unlimited?** Yes If No (1): Indicate Number of trips: If No (2): Select Periodicity: **Select 1 Type of Transportation:** Round Trip If Days: Indicate number of days: **Select (All Applicable) Modes of Transportation:** May be taxi, bus, van, or other **Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **MOOP:** No If Yes (1): MOOP Amount: If Yes (2): MOOP Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from: Health Plan or its contractor** **Referral required?** No	Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs. Transportation to medical facilities for the performance of medical services or procedures which are excluded under the Plan Benefit Package is excluded. IDAPA 16.03.09.861-872

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Any location	Not Required		
11A	Durable Medical Equipment - Not required in addition to Medicare b/c Medicaid follows the Medicare DME manual	Durable Medical Equipment for Use Outside the Home	Not Required		
		Other 1: Provide label			

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 2: Provide label			
11B	Prosthetics/Medical Supplies	Non-Medicare Service: Plan to provide label; Medicaid name is "Prosthetic Devices"	Required	**Max Benefit Coverage: Yes** If Yes: Max Coverage Amount: Limit of one refitting, repair or additional part. If Yes: Max Coverage Periodicity: Calendar Year **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from:** Must be prescribed by a physician. **Referral required?** Yes	IDAPA 16.03.09.771-773
13A	Acupuncture	Number of Treatments	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
13B	Over-the-Counter Items	MMPs should not enter OTC drugs / items included in integrated formulary and captured in section Rx of the PBP	Not Required		
13C	Meal Benefit - Home Delivered Meals	Aged and Disabled (A&D) Waiver Benefit for A&D Waiver Participants	Required	**Max Benefit Coverage:** Yes If Yes: Max Coverage Amount: 2 meals If Yes: Max Coverage Periodicity: Daily **Enrollee MOOP:** No If Yes: MOOP Amount: If Yes: MOOP Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** Yes If Yes: Copayment Amount: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	One (1) to two (2) meals per day may be provided to an Enrollee who: a. Rents or owns a home; b. Is alone for significant parts of the day; c. Has no caregiver for extended periods of time; and d. Is unable to prepare a meal without assistance. IDAPA 16.03.10.326.10
13D	Personal Emergency Response System	Aged and Disabled (A&D) Waiver Benefit for A&D Waiver Participants	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: One Unit If Yes (2): Max Coverage Periodicity: One Unit at Any Time **Enrollee MOOP:** No If Yes (1): MOOP Amount: If Yes (2): MOOP Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** Yes If Yes: Copayment Amount: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Registered nurse or licensed practical or vocational nurse **Referral required?** Yes	This service is limited to participants who: a. Rent or own a home, or live with unpaid caregivers; b. Are alone for significant parts of the day; c. Have no caregiver for extended periods of time; and d. Would otherwise require extensive, routine supervision. IDAPA 16.03.10.326.13

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
13E	Skilled Nursing	Aged and Disabled (A&D) Waiver Benefit for A&D Waiver Participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee MOOP:** No If Yes (1): MOOP Amount: If Yes (2): MOOP Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** Yes If Yes: Copayment Amount: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	These services are not appropriate if they are less cost effective than a Home Health visit. IDAPA 16.03.10.326.15
13F	Specific Pregnancy-Related Services	Specific Pregnancy-Related Services	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: Two (2) visits during covered period for each of the following: individual and family social services, nursing services, and nutrition services; Nine (9) maternity nursing visits for maternity; If Yes (2): Max Coverage Periodicity: Covered period (after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs.) **Enrollee MOOP:** No If Yes (1): MOOP Amount: If Yes (2): MOOP Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from:** Physician, nurse practitioner or nurse midwife **Referral required?** Yes	IDAPA 16.03.09.890-895

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
13H	Additional Services	EPSDT Services	Not Required		
		Tobacco Cessation Counseling for Pregnant Women	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** PCP **Referral required?** Yes	
		Freestanding Birth Center Services	Not Required		
		Respiratory Care Services	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Family Planning Services	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Patient Liability Minimum: If Yes (2): Copayment Maximum: No. **Authorization from:** Prior authorization is not permitted. **Referral required?** No	IDAPA 16.03.09.681-685
		Nursing Home Services (Skilled Nursing Facilities are included above)	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Home and Community Based Services (i.e. Aged and Disabled Waiver Services - which are specifically listed in 13C, 13D, 13E, and 13H)	Required	**Max Benefit Coverage:** Varies amongst the 18 HCBS Aged and Disabled waiver services. If Yes (1): Max Coverage Amount: Refer to the specific waiver services for individualized information. If Yes (2): Max Coverage Periodicity: Refer to the specific waiver services for individualized information. **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes - but only for adult day health, day habilitation, homemaker, residential habilitation, respite, supported employment, attendant care, adult residential care, chore services, companion services, consultation, home delivered meals, personal emergency response system, and skilled nursing services. If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330
		Personal Care Services (PCS)	Required	**Max Benefit Coverage:** Yes If Yes: Max Coverage Amount: 16 hours If Yes: Max Coverage Periodicity: Weekly **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** A registered nurse must determine a need for Personal Care Services through the Uniform Assessment Instrument. **Referral required?** Yes	IDAPA 16.03.10.300-308

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Self-Directed Personal Assistance Services	Required	Note: self-direction must be offered as an option for the following Aged and Disabled waiver services: attendant care, homemaker, chore, companion, consultation and skilled nursing services. **Max Benefit Coverage:** See descriptions for individual waiver services. If Yes (1): Max Coverage Amount: See descriptions for individual waiver services. If Yes (2): Max Coverage Periodicity: See descriptions for individual waiver services. **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: See descriptions for individual waiver services. If Yes (2): Copayment Maximum: See descriptions for individual waiver services. **Authorization from:** Registered nurse or licensed practical or vocational nurse **Referral required?** Yes	See Aged & Disabled Waiver, Appendix E, at http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/AandDWaiver.pdf
		Private Duty Nursing Services	Not Required		
		Case Management (Long Term Care)	Not Required		
		Institution for Mental Disease Services	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Services in an Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID)	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Patient Liability:** Yes If Yes (1): Patient Liability Minimum: IDHW will report the monthly amount, calculated under IDAPA 16.03.05.722-726, to Health Plans. If Yes (2): Patient Liability Maximum: IDHW will report the monthly amount, calculated under IDAPA 16.03.05.722-726, to Health Plans. **Authorization from:** Medical Home **Referral required?** Yes	Patient liability will be reported by IDHW (see IDAPA 16.03.05.722-726) for Members in ICF/IDs and Health Plans will determine how it will be collected. IDAPA 16.03.10.580-633
		Targeted Case Management for Persons with Developmental Disabilities and/or Serious and Persistent Mental Illness, and Primary Care Case Management (PCCM)	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: Five (5) hours for participants with mental illness, and four and a half (4.5) hours for participants with developmental disabilities. If Yes (2): Max Coverage Periodicity: Monthly **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Medical Home **Referral required?** No	Targeted Case Management-16.03.10.720-728, PCCM-16.03.09.560-566
		Other 1: Adult Day Health - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: 12 hours If Yes (2): Max Coverage Periodicity: Daily **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	Participants residing in a Certified Family Home may only receive adult day health care services if there is an assessed unmet socialization need that cannot be provided by the certified family home provider. Adult day health care services are not offered to participants who reside in a Residential Assisted Living Facility (RALF). IDAPA 16.03.10.320-330

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 2: Day Habilitation - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: 30 hours If Yes (2): Max Coverage Periodicity: Weekly **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330
		Other 3: Homemaker Care, Attendant Care, and Respite - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	Homemaker services are available when there is no one else in the household capable of performing the tasks. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. IDAPA 16.03.10.320-330

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 4: Residential Habilitation - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330
		Other 5: Supported Employment - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 6: Adult Residential Care - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330
		Other 7: Chore Service and Companion Services - A&D Waiver benefits for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	Chore services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of chore services. Chore services are limited to the services provided in a home rented or owned by the participant. Companion services are not authorized for participants living in Certified Family Homes or RALFs. Companion services do not include room and board. IDAPA 16.03.10.320-330

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 8: Consultation Services - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes If Yes (1): Copayment Minimum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. If Yes (2): Copayment Maximum: Deductions are subtracted from countable income after exclusions to determine the base amount subject to cost participation in the form co-payments per IDAPA 16.03.18. **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330
		Other 9: Dental Services - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** Yes -varies based on type of dental service. If Yes (1): Max Coverage Amount: See pgs. 10-15 of http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/AandDWaiver.pdf for additional information If Yes (2): Max Coverage Periodicity: See pgs. 10-15 of http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/AandDWaiver.pdf for additional information **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	IDAPA 16.03.10.320-330

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 10: Environmental Accessibility Adaptations; and Specialized Medical Equipment and Supplies - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	Unless otherwise authorized, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. Portable or non-stationary modifications may be made when such modifications can follow the participant to his next place of residence or be returned. IDAPA 16.03.10.320-330
		Other 11: Non-medical Transportation - A&D Waiver benefit for A&D Waiver participants	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan (based on determination in Uniform Assessment Instrument) **Referral required?** Yes	IDAPA 16.03.10.320-330
		Other 12: Health Home Services	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** Yes	Health Home-16.03.09.570-574

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Other 13: Community-Based Outpatient Behavioral Health Services (Community-Based Outpatient Behavioral Health Services; Screening, Evaluation and Diagnostic Assessments; Treatment Planning; Psychological and Neuropsychological Testing; Psychotherapy (Individual, Group, and Family); Pharmacologic Management; Partial Care Treatment; Behavioral Health Nursing; Drug Screening; Community-Based Rehabilitation and Substance Use Disorder Treatment Services)	Required	**Max Benefit Coverage:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Registered nurse or licensed practical or vocational nurse **Referral required?** Yes	IDAPA rules are under development.
14C	Supplemental Education / Wellness Programs	Health Education	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Nutrition Services	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: Two (2) visits If Yes (2): Max Coverage Periodicity: Yearly **Enrollee MOOP:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Amount: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** No If Yes (1): Copayment Amount: **Authorization from:** Physician **Referral required?** Yes	Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as Preventive Health Assistance (PHA) benefits. IDAPA 16.03.09.630-632
		Additional Smoking and Tobacco Use Cessation - not required under this name, but fits into broader category of "Prevention and Health Assistance Benefits" below	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Prevention and Health Assistance Benefits	Required	**Max Benefit Coverage:** Yes If Yes (1): Max Coverage Amount: $200 (= 200 "points") for Behavioral preventive health assistance (PHA) and $120 (=120 points) for Wellness PHA, per IDAPA 16.03.09.622 If Yes (2): Max Coverage Periodicity: Yearly **Enrollee MOOP:** No If Yes (1): Max Coverage Amount: If Yes (2): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Amount: **Enrollee Deductible:** No If Yes: Deductible Amount: **Enrollee Copayment:** No If Yes (1): Copayment Amount: **Authorization from:** The reimbursable products and services of each vendor must be prior approved by the Health Plan. **Referral required?** Yes	PHA benefits will be available when individuals complete specified activities in preparation for addressing the targeted health condition. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational material related to the condition. IDADPA 16.03.09.620-626
		Membership in Health Club / Fitness Classes	Not Required		
		Nursing Hotline - a nurse line is required but is not considered a formal, covered service.	Not Required		
		Enhanced Disease Management	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Tele-Monitoring	Not Required		
		Web/Phone-Based Technology	Not Required		
15	Home Infusion Bundled Services	Does plan bundle Part D drug costs with admin/supplies as a supplemental benefits?	Not Required		
		Does Medicaid pay for Part D home infusion drug admin/supplies? Yes/No	Not Required		
16A	Preventive Dental	Oral Exams	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Prophylaxis (Cleaning)	Not Required		
		Fluoride Treatment	Not Required		
		Dental X-Rays	Not Required		
16B	Comprehensive Dental	Non-routine Services	Required	**Unlimited Benefit:** Yes If No (1): Number of visits: If No (2): Periodicity: **Max Benefit Coverage:** No If Yes (1): Type: Covered under Preventative Dental (16A) / Plan-specified amount per period If Yes (2): Applies to: In-network services only / Both in-network and out-of-network If Yes (3): Max Coverage Amount: If Yes (4): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	Dental services listed under IDAPA 16.03.10.083.03 are covered for all dual eligibles, and dental services listed in IDAPA 16.03.10.083.04 are covered for pregnant women. IDAPA 16.03.10.083.03 includes: Intraoral periapical film; Additional intraoral periapical films; Panoramic film; Extraction; Surgical removal of erupted tooth; Removal of impacted tooth, soft tissue; Removal of impacted tooth, partially bony; Removal of impacted tooth, completely bony; Removal of impacted tooth, with complications; Surgical removal of residual tooth roots; Oroantral fistula closure; Primary closure of sinus perforation; Biopsy of hard oral tissue; Biopsy of soft oral tissue; Excision of malignant tumor <1.25 cm; Excision of malignant tumor >1.25 cm; Incision and drainage of abscess; Incision and drainage of abscess, complicated; Minor palliative treatment of dental pain; Deep sedation/anesthesia first 30 minutes; Regional block anesthesia; Analgesia, anxiolysis, nitrous oxide; IV conscious sedation first 30 minutes; IV conscious sedation each additional 15 minutes; Non IV conscious sedation; Hospital call; Therapeutic parenteral drug single administration; Other drugs and/or

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Diagnostic Services - for pregnant women	Required	**Unlimited Benefit:** Yes If No (1): Number of visits: If No (2): Periodicity: **Max Benefit Coverage:** No If Yes (1): Type: Covered under Preventative Dental (16A) / Plan-specified amount per period If Yes (2): Applies to: In-network services only / Both in-network and out-of-network If Yes (3): Max Coverage Amount: If Yes (4): Max Coverage Periodicity: **Enrollee Coinsurance:** Yes/No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** Yes/No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	medicaments by report; IDAPA 16.03.10.083.04 includes, broadly, preventative and problem-focused exams, diagnostic, restorative, endodontic, periodontic, and oral surgery benefits.
		Restorative Services - for pregnant women	Required	**Unlimited Benefit:** Yes If No (1): Number of visits: If No (2): Periodicity: **Max Benefit Coverage:** No If Yes (1): Type: Covered under Preventative Dental (16A) / Plan-specified amount per period If Yes (2): Applies to: In-network services only / Both in-network and out-of-network If Yes (3): Max Coverage Amount: If Yes (4): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Endodontics and Periodontics - for pregnant women, only; Extractions - for all dual eligibles	Required	**Unlimited Benefit:** Yes If No (1): Number of visits: If No (2): Periodicity: **Max Benefit Coverage:** No If Yes (1): Type: Covered under Preventative Dental (16A) / Plan-specified amount per period If Yes (2): Applies to: In-network services only / Both in-network and out-of-network If Yes (3): Max Coverage Amount: If Yes (4): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	
		Oral, Oral / Maxillofacial Surgery, Other Services	Required	**Unlimited Benefit:** Yes If No (1): Number of visits: If No (2): Periodicity: **Max Benefit Coverage:** No If Yes (1): Type: Covered under Preventative Dental (16A) / Plan-specified amount per period If Yes (2): Applies to: In-network services only / Both in-network and out-of-network If Yes (3): Max Coverage Amount: If Yes (4): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
17A	Eye Exams	Routine Eye Exams	Required	**Unlimited Benefit:** No If No (1): Number of visits: One (1) If No (2): Periodicity: Medically necessary eye examinations are available when the participant has a chronic condition that may damage the eye, or when there is an acute condition that, if left untreated, may cause permanent or chronic damage to the eye. **Max Benefit Coverage:** No If Yes (1): Applies to: In-network services only / Both in-network and out-of-network If Yes (2): Max Coverage Amount: If Yes (3): Max Coverage Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Health Plan **Referral required?** No	Will pay participating physicians and optometrists for medically necessary eye examinations when the participant has a chronic condition that may damage the eye, or when there is an acute condition that, if left untreated, may cause permanent or chronic damage to the eye. IDAPA 16.03.09.781-785
17B	Eye Wear	Contact Lenses	Required	**Unlimited Benefit:** No If No (1): Number: One (1) If No (2): Periodicity: Only covered when the lenses are necessary to treat a medical condition that can progressively impact the participant's health or vision (i.e. keratoconus). One pair of contacts or one set of frames and lenses is covered following cataract surgery. **Max Benefit Coverage:** No If Yes (1): Select: Covered under eye exams category (17a) / Plan-specified amount per period If Yes (2): Applies: In-network services only / Both in-network and out-of-network If Yes (3): Offer Combined Max Plan Benefit Coverage Amount for All Eyewear: Yes / No If Yes (3-1): Max Combined Coverage Amount: If Yes (3-2): Max Combined Coverage Periodicity: If Yes (4): Max Individual Coverage Amount: If Yes (5): Max Individual Coverage Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from:** Health Plan **Referral required?** No	IDAPA 16.03.09.781-785

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Eye Glasses (Lenses and Frames)	Required	**Unlimited Benefit:** No If No (1): Number: One (1) If No (2): Periodicity: Only when necessary to treat a medical condition or following cataract surgery. **Max Benefit Coverage:** No If Yes (1): Select: Covered under eye exams category (17a) / Plan-specified amount per period If Yes (2): Applies: In-network services only / Both in-network and out-of-network If Yes (3): Offer Combined Max Plan Benefit Coverage Amount for All Eyewear: Yes / No If Yes (3-1): Max Combined Coverage Amount: If Yes (3-2): Max Combined Coverage Periodicity: If Yes (4): Max Individual Coverage Amount: If Yes (5): Max Individual Coverage Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from:** Health Plan **Referral required?** No	
		Eye Glass Lenses	Required	**Unlimited Benefit:** No If No (1): Number: One (1) If No (2): Periodicity: Following cataract surgery or when necessary to prevent permanent damage to the eye. **Max Benefit Coverage:** No If Yes (1): Select: Covered under eye exams category (17a) / Plan-specified amount per period If Yes (2): Applies: In-network services only / Both in-network and out-of-network If Yes (3): Offer Combined Max Plan Benefit Coverage Amount for All Eyewear: Yes / No If Yes (3-1): Max Combined Coverage Amount: If Yes (3-2): Max Combined Coverage Periodicity: If Yes (4): Max Individual Coverage Amount: If Yes (5): Max Individual Coverage Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from:** Health Plan **Referral required?** No	

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Eye Glass Frames	Required	**Unlimited Benefit:** No If No (1): Number: One (1) If No (2): Periodicity: When necessary to prevent permanent damage to the eye. **Max Benefit Coverage:** No If Yes (1): Select: Covered under eye exams category (17a) / Plan-specified amount per period If Yes (2): Applies: In-network services only / Both in-network and out-of-network If Yes (3): Offer Combined Max Plan Benefit Coverage Amount for All Eyewear: Yes / No If Yes (3-1): Max Combined Coverage Amount: If Yes (3-2): Max Combined Coverage Periodicity: If Yes (4): Max Individual Coverage Amount: If Yes (5): Max Individual Coverage Periodicity: **Enrollee Coinsurance:** No If Yes: Coinsurance Percentage: **Enrollee Copayment:** No If Yes: Copayment Amount: **Authorization from:** Health Plan **Referral required?** No	
		Upgrades	Not Required		
18A	Hearing Exams	Routine Hearing Exams (Audiology Services)	Required	**Is the Benefit unlimited?** No If No (1): Indicate Number: One (1) If No (2): Select Periodicity: Diagnostic screening services are available when necessary to obtain a differential diagnosis. Max Benefit Coverage: No If Yes (1): Applies: In-network services only / Both in-network and out-of-network If Yes (2): Amount: If Yes (3): Periodicity: **Enrollee Coinsurance:** No If Yes (1): Coinsurance Minimum: If Yes (2): Coinsurance Maximum: **Enrollee Copayment:** No If Yes (1): Copayment Minimum: If Yes (2): Copayment Maximum: **Authorization from:** Physician or midlevel practitioner **Referral required?** Yes	IDAPA 16.03.09.740-745

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Fitting / Evaluation for Hearing Aid	Not Required		
18B	Hearing Aids	Hearing Aids (All Types)	Not Required		
		Hearing Aids - Inner Ear	Not Required		
		Hearing Aids - Outer Ear	Not Required		

PBP Section	Service Category Description	Supplemental Benefit	Required by State?	Proposed HPMS Instruction All benefits entered as "mandatory"	Required Language in HPMS Notes Field and/or Pertinent Administrative Rule 3,000 character maximum (B-14C has a 1,000 maximum)
		Hearing Aids - Over the Ear	Not Required		