Service Request Type Source: Abilis Health Plan 2026 PBP - Evidence of Coverage	**APPLIES TO:** **Abilis** (ABHP-001) ; **Abilis Community** (ABHCP-002) ; or **Both**	**Prior Authorization Required** (Yes / No)	**Notification within 24-hours Following Admission Event** (Yes / No)	**Continuation of Services Approval Required** (Yes / No)	**Pre-claim Retrospective Review Allowed** (Yes / No)	**2025 to 2026 Change?**
Ambulance Services (Non-emergent)	Both	Yes	No	Not Applicable	No	No
Ambulatory Surgical Centers (ASC) **Services**	Both	Yes	No	Not Applicable	No	No
Cardiac & Pulmonary Rehab Services	Both	Yes	No	Yes	No	No
Chiropractic Services	**ABHP**-001	Yes	No	Yes	No	No
Diabetic Supplies & Services / Diabetic Therapeutic Shoes & Inserts *Auth Required for billed charges in excess of $250	Both	Yes*	No	Not Applicable	No	No
Durable Medical Equipment (DME) *Auth Required for billed charges in excess of $250	Both	Yes*	No	Not Applicable	No	No
Emergent & Urgently Needed Services (USA territories only)	Both	No	Yes	Not Applicable	Yes	No
Home Health Services	Both	Yes	No	Yes	No	No
INN Specialist Referrals If PA is preferred: **Initiate Review** If a non-contracted specialty referral request: **Attempt to redirect within Abilis Network**	Both	No	No	No	No	No
Inpatient Hospital - ACUTE ***PA Required - *UNLESS*** admitted due to a medical emergency.	Both	Yes*	Yes	Yes	Yes*	No
Inpatient Hospital - PSYCHIATRIC ***PA Required - *UNLESS*** admitted due to a medical emergency.	Both	Yes*	Yes	Yes	Yes*	No
Opioid Treatment Program Services	Both	Yes	Yes	Yes	No	No
Outpatient Blood Services (Transfusions)	Both	No	No	No	No	No
Outpatient Diagnostic High tech Radiological Services ***Auth Required for High-Tech Radiological Services ONLY:** MRI, MRA, PET, CTA, CT scans & SPECT	Both	Yes*	No	Not Applicable	No	No
Outpatient Diagnostic Procedures, Tests, & Lab Services ***EXCEPTION:** Tests rendered in contracted NF/ALF - *OR* - in contracted Physician office: **PA NOT REQUIRED***	Both	Yes*	No	Not Applicable	No	No
Outpatient Hospital Services	Both	Yes	No	Not Applicable	No	No
Outpatient Observations	Both	Yes	Yes	Yes	No	No
Outpatient Psychiatric Services	Both	No	No	No	No	No
Outpatient Substance Abuse Services	Both	No	No	No	No	No
Part B Drugs: Chemotherapy (Following Initial Chemotherapy Only) *Auth Required for billed charges in excess of $250	Both	Yes*	No	Yes	No	No
Part B Drugs: Chemotherapy *Auth Required for billed charges in excess of $250	Both	Yes	No	Yes	No	No
Part B Drugs: *Other* *Auth Required for billed charges in excess of $250	Both	Yes*	No	Yes	No	No
Partial Hospitalization	Both	Yes	No	Yes	No	No
Physician Specialist Consultation: Medical / Behavioral	Both	No	No	No	No	No
Podiatry Services (Routine Foot Care) **ABHP - 001** Plan covers **12** Podiatry visits per year **ABHCP - 002** Plan covers **6** Podiatry visits per year	Both	No	No	Not Applicable	No	No
Prosthetics / Medical Supplies *Auth Required for billed charges in excess of $250	Both	Yes*	No	Yes	No	No
Renal (Kidney) Dialysis	Both	No	No	No	No	No
Skilled Nursing Facility Admission	Both	Yes	Yes	Yes	No	No

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Supplemental Benefit: Dental Services* **Preventive Dental** (Per Plan Year): 2 Oral Exam Visits, 2 Dental X-Rays and 2 Prophylaxis (cleaning) Visits **Comprehensive Dental** Non-routine, Diagnostic, Medicare-covered Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral / Maxillofacial Surgery **Note:** All covered supplemental dental benefits are limited to a combined total maximum plan benefit allowed (Plan paid amount) per plan year: ABHP-001 Combined Max Allowed: $2,000 ABHCP-002 Combined Max Allowed: $2,400	**Both**	No	No	No	No	No
Supplemental Benefit: Foot Care* **ABHP - 001** Plan covers 12 Podiatry visits per year **ABHCP - 002** Plan covers 6 Podiatry visits per year	**Both**	No	No	Not Applicable	No	No
Supplmental Benefit: Home-Based Palliative Care*	**ABHP**-001	Yes	No	No	No	No
Suplemental Benefit: Hearing Services* **Plan covers** One (1) Routine Hearing Exam & Hearing-aid Fitting/Eval per year **Plan pays** up to $4,000 every two years	**Both**	No	No	No	No	No
Supplemental Benefit: OTC Items* (Over-the-Counter) Including Incontinence Supplies **Must use Preferred Provider - Unused benefits** are carried forward for the remainder of plan year. **Expiring** at the end of the plan year. **OTC Limited to $200 /Quarter**	**Both**	No	No	No	No	Yes*
Supplemental Benefit: for Chronically Ill* **Personal Care** (*General Supports for Living*) **/ Healthy Food Items.** **Must use Preferred Provider - Unused benefits do not rollover to next month/year** Healthy Food/Produce - **$75 /month** Personal Care Items - **$75 / month** e.g. soap, shampoo, razors, adult diapers	**Both**	No	No	No	No	Yes*
Supplmental Benefit: Telehealth Services* **Includes:** Primary Care Visits, Physician Specialist Services, Individual & Group Sessions for Psychiatric Services, Kidney Disease Education Services, Diabetes Self-Management Training and Dialysis Services	**Both**	No	No	No	No	No
Supplental Benefit: Vision Services* **ABHP-001 Plan covers** One (1) Routine Eye Exam and $275 toward eyewear cost **ABHCP-002 Plan covers** One (1) Routine Eye Exam and $325 toward eyewear cost	**Both**	No	No	No	No	No
Telehealth Services (Additional)	**Both**	No	No	No	No	No
Therapeutic Radiology Services*	**Both**	Yes	No	Not Applicable	No	No
Therapy Services (PT/OT/ST - Capped)* Performed at NF/ALF	**Both**	No	No	No	No	No
Transportation Services* Plan Covers **50 one-way trips to approved medical locations** with no cost-share for members.	**Both**	No	No	Not Applicable	No	No