

DRAFT: Adult Benefit Package*

Services	Adult Benefit Package
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Services and Medical and Surgical Services provided by a Dentist	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	No limits
Optometrist Services	2 visits (exams) per calendar year
Hospice Care	The only key limitation is related to respite care, which may not exceed a total of 5 days in a 60-day certification period.
Radiology (For example: X-Rays, MRIs, CTs)	No limits
Dental Care Services	<p style="text-align: center;">Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation.</p> <p style="text-align: center;">Key Limitations:</p> <p style="text-align: center;">Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception</p>
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	Only to and from MA covered services.
Family Planning Clinic, Services and Supplies	No limits
Renal Dialysis	<ul style="list-style-type: none"> Initial training for home dialysis is limited to 24 sessions per patient per calendar year. Backup visits to the facility limited to no more than 75 per calendar year

Category 2: Emergency Services	
Emergency Room	No limits
Ambulance	No limits
Category 3: Hospitalization	
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	No limits
Outpatient Drug and Alcohol Treatment	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	No limits
Crisis	No limits
Targeted Case Management – other than Behavioral Health	Limited to individuals identified in the target group (No limits)
Targeted Case Management – Behavioral Health Only	Limited to individuals with SMI only (No limits)
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	No limits
Category 7: Rehabilitation and Habilitation Services and Devices	
Skilled Nursing Facility	365 days per calendar year
Home Health Care Includes Nursing, Aide and Therapy services	Unlimited for first 28 days; limited to 15 days every month thereafter
ICF/IID and ICF/ORC	Requires an institutional level of care (No limits)
Durable Medical Equipment	No limits

Prosthetics and Orthotics	Orthopedic Shoes and Hearing Aids are not covered. Coverage for low vision aids is limited to 1 per 2 calendar years. Coverage for an eye ocular is limited to 1 per calendar year.
Eyeglass Lenses	Limited to individuals with aphakia 4 lenses per calendar year
Eyeglass Frames	Limited to individuals with aphakia 2 frames per calendar year
Contact Lenses	Limited to individuals with aphakia 4 lenses per calendar year
Medical Supplies	No limits
Therapy (Physical, Occupational, Speech)- Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider
Therapy (Physical, Occupational, Speech)- Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventative / Wellness Services and Chronic Care	
Tobacco Cessation**	70 visits per calendar year

* Children's benefit plan will include all medically necessary services without limitation.

** Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force.
For a full listing of preventative services beyond tobacco cessation, please contact your MCO.

PCO Benefit Package

Services	PCO
	CMS Approved as of 1 Jan 2015
Category 1: Ambulatory Services	
Primary Care Provider	No limits
Physician Office	No limits
Certified Registered Nurse Practitioner	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below
Independent Clinic	No limits
Outpatient Hospital Clinic	No limits
Podiatrist Services	No limits
Chiropractor Services	20 visits per year
Optometrist Services	1 visit per two years
Hospice Care	No limits. Respite care is not provided.
Radiology (For example: X-Rays, MRIs, CTs)	No limits
Dental Care Services	NOT COVERED **
Outpatient Hospital Short Procedure Unit (SPU)	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits
Non-Emergency Medical Transport	NOT COVERED **
Family Planning Clinic	No limits
Renal Dialysis	NOT COVERED **
Category 2: Emergency Services	
Emergency Room	<ul style="list-style-type: none"> • No limits on emergency services. • Non-emergency services are not covered.
Ambulance	<ul style="list-style-type: none"> • No limits on emergency ambulance services. • Non-emergency ambulance services are not covered.
Category 3: Hospitalization	

Services	PCO
	CMS Approved as of 1 Jan 2015
Inpatient Acute Hospital	No limits
Inpatient Rehab Hospital	No limits
Inpatient Psychiatric Hospital	No limits
Inpatient Drug & Alcohol	No limits
Category 4: Maternity and Newborn	
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits
Category 5: Mental Health and Substance Abuse (Behavioral Health)	
Outpatient Psychiatric Clinic	No limits
Mobile Mental Health Treatment	NOT COVERED **
Outpatient Drug and Alcohol Treatment	No limits
Residential Treatment Facility (Non-Hospital Residential Drug & Alcohol)	No limits
Methadone Maintenance	No limits
Clozapine	No limits
Psychiatric Partial Hospital	No limits
Peer Support	NOT COVERED **
Crisis	No limits
Targeted Case Management – other than Behavioral Health	NOT COVERED **
Targeted Case Management – Behavioral Health Only	NOT COVERED **
Category 6: Prescription Drugs	
Prescription Drugs	No limits
Nutritional Supplements	NOT COVERED **
Category 7: Rehabilitation and Habilitation Services and Devices	
Skilled Nursing Facility	120 days per calendar year
Home Health Care	60 visits per year
ICF/IID and ICF/ORC	NOT COVERED **
Durable Medical Equipment	No limits
Eyeglass Lenses	NOT COVERED **

Services	PCO
	CMS Approved as of 1 Jan 2015
Eyeglass Frames	NOT COVERED **
Contact Lenses	NOT COVERED **
Medical Supplies	NOT COVERED ** (Except diabetic supplies provided by pharmacies, which are not limited)
Therapy (Physical, Occupational, Speech)-Rehabilitative	<ul style="list-style-type: none"> • 30 visits per calendar year combined for Physical and Occupational Therapy • 30 visits per calendar year for Speech Therapy
Therapy (Physical, Occupational, Speech)-Habilitative	<ul style="list-style-type: none"> • 30 visits per calendar year combined for Physical and Occupational Therapy • 30 visits per calendar year for Speech Therapy
Category 8: Laboratory Services	
Laboratory	No limits
Category 9: Preventative / Wellness Services and Chronic Care	
Tobacco Cessation***	As recommended by the US Preventive Services Task Force

* Children's benefit plan will include all medically necessary services without limitation.

** Optional for PCO, not an essential health benefit.

*** Tobacco cessation is one of the preventative services as recommended by the US Preventative Services Task Force. For a full listing of preventative services beyond tobacco cessation, please contact your MCO and PCO.