

# Benefit Plan Comparison

Services	Healthy (Low Risk Interim)	PCO	Healthy Plus (High risk)
	Current MA Benefit as of 1 Jan 2015	CMS Approved as of 1 Jan 2015	CMS Approved as of 1 Jan 2015
<b>Category 1: Ambulatory Services</b>			
Primary Care Provider	No limits	No limits	No limits
Physician Office	No limits	No limits	No limits
Certified Registered Nurse Practitioner	No limits	No limits	No limits
Federally Qualified Health Center/Rural Health Clinic	No limits except for Dental Care Services as described below	No limits except for Dental Care Services as described below	No limits except for Dental Care Services as described below
Independent Clinic	No limits	No limits	No limits
Outpatient Hospital Clinic	No limits	No limits	No limits
Podiatrist Services	No limits	No limits	No limits
Chiropractor Services	No limits	20 visits per year	10 visits per calendar year
Optometrist Services	2 visits (exams) per calendar year	1 visit per two years	1 visit 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.	No limits. Respite care is not provided.	No limits, except for 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	No limits	No limits

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Dental Care Services	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception	<b>NOT COVERED **</b>	Diagnostic, preventive, restorative, and surgical dental procedures, prosthodontics and sedation. Key Limitations: Dentures 1 per lifetime, Exams/prophylaxis 1 per 180 days, Crowns, Periodontics and Endodontics only via approved benefit limit exception
Outpatient Hospital Short Procedure Unit (SPU)	No limits	No limits	No limits
Outpatient Ambulatory Surgical Center (ASC)	No limits	No limits	No limits
Non-Emergency Medical Transport	Only to and from MA covered services.	<b>NOT COVERED **</b>	Only to and from MA covered services.
Family Planning Clinic	No limits	No limits	No limits
Renal Dialysis	<ul style="list-style-type: none"> <li>Initial training for home dialysis is limited to 24 sessions per patient per calendar year.</li> <li>Backup visits to the facility limited to no more than 26 per calendar year</li> </ul>	<b>NOT COVERED **</b>	<ul style="list-style-type: none"> <li>Initial training for home dialysis is limited to 24 sessions per patient per calendar year.</li> <li>Backup visits to the facility limited to no more than 75 per calendar year</li> </ul>
<b>Category 2: Emergency Services</b>			
Emergency Room	No limits	<ul style="list-style-type: none"> <li>No limits on emergency services.</li> <li>Non-emergency services are not covered.</li> </ul>	No limits
Ambulance	No limits	<ul style="list-style-type: none"> <li>No limits on emergency ambulance services.</li> <li>Non-emergency ambulance services are not covered.</li> </ul>	No limits

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<b>Category 3: Hospitalization</b>			
Inpatient Acute Hospital	No limits	No limits	No limits
Inpatient Rehab Hospital	1 admit per calendar year	No limits	No limits
Inpatient Psychiatric Hospital	30 days per calendar year	No limits	No limits
Inpatient Drug & Alcohol	No limits	No limits	No limits
<b>Category 4: Maternity and Newborn</b>			
Maternity – Physician, Certified Nurse Midwives, Birth Centers	No limits	No limits	No limits
<b>Category 5: Mental Health and Substance Abuse (Behavioral Health)</b>			
Outpatient Psychiatric Clinic	Five hours or 10 one-half hour sessions of psychotherapy per recipient per 30 consecutive days	No limits	No limits
Mobile Mental Health Treatment	Same as OP Psychiatric Clinic	<b>NOT COVERED **</b>	No limits
Outpatient Drug and Alcohol Treatment	<ul style="list-style-type: none"> <li>Opiate Detox: 42 visits per 365 days</li> <li>Chemotherapy/Drug-free visits: 3 visits per 30 days</li> </ul>	No limits	No limits
Residential Treatment Facility (Non-Hospital Residential Drug & Alcohol)	<b>NOT COVERED</b>	No limits	No limits
Methadone Maintenance	One visit per day / 7 visits per week	No limits	No limits
Clozapine	Limited to persons with Schizophrenia 1 per week	No limits	No limits
Psychiatric Partial Hospital	540 hours per calendar year	No limits	No limits
Peer Support	4 hours per day / 900 hours per year	<b>NOT COVERED **</b>	No limits

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Crisis	No limits	No limits	No limits
Targeted Case Management – other than Behavioral Health	Limited to individuals identified in the target group (No limits)	<b>NOT COVERED **</b>	Limited to individuals identified in the target group (No limits)
Targeted Case Management – Behavioral Health Only	Limited to individuals with SMI only (No limits)	<b>NOT COVERED **</b>	Limited to individuals with SMI only (No limits)
<b>Category 6: Prescription Drugs</b>			
Prescription Drugs	6 per month	No limits	No limits
Nutritional Supplements	No limits	<b>NOT COVERED **</b>	No limits
<b>Category 7: Rehabilitation and Habilitation Services and Devices</b>			
Skilled Nursing Facility	365 days per calendar year	120 days per calendar year	365 days per calendar year
Home Health Care	Unlimited for first 28 days; limited to 15 days every month thereafter	60 visits per year	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)	<b>NOT COVERED **</b>	Requires an institutional level of care (No limits)
Durable Medical Equipment	No limits	No limits	No limits
Eyeglass Lenses	Limited to individuals with aphakia 4 lenses per calendar year	<b>NOT COVERED **</b>	Limited to individuals with aphakia 4 lenses per calendar year
Eyeglass Frames	Limited to individuals with aphakia 2 frames per calendar year	<b>NOT COVERED **</b>	Limited to individuals with aphakia 2 frames per calendar year
Contact Lenses	Limited to individuals with aphakia 4 lenses per calendar year	<b>NOT COVERED **</b>	Limited to individuals with aphakia 4 lenses per calendar year
Medical Supplies	No limits	<b>NOT COVERED **</b> (Except diabetic supplies provided by pharmacies, which are not limited)	\$2500 per calendar year Diabetic supplies provided by pharmacies are not limited

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Therapy (Physical, Occupational, Speech)-Rehabilitative	Only when provided by a hospital, outpatient clinic, or home health provider	<ul style="list-style-type: none"> <li>• 30 visits per calendar year combined for Physical and Occupational Therapy</li> <li>• 30 visits per calendar year for Speech Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• 30 visits per calendar year combined for Physical and Occupational Therapy</li> <li>• 30 visits per calendar year for Speech Therapy</li> </ul>
Therapy (Physical, Occupational, Speech)-Habilitative	Only when provided by a hospital, outpatient clinic, or home health provider	<ul style="list-style-type: none"> <li>• 30 visits per calendar year combined for Physical and Occupational Therapy</li> <li>• 30 visits per calendar year for Speech Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• 30 visits per calendar year combined for Physical and Occupational Therapy</li> <li>• 30 visits per calendar year for Speech Therapy</li> </ul>
<b>Category 8: Laboratory Services</b>			
Laboratory	No limits	No limits	No limits
<b>Category 9: Preventative / Wellness Services and Chronic Care</b>			
Tobacco Cessation***	70 visits per calendar year	As recommended by the US Preventive Services Task Force	70 visits per calendar year

\* 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.