

# HEALTH CARE BENEFITS

## Member Benefits

All benefits have to be medically necessary. Benefits with limits are counted on a calendar year.

Benefit	Medicaid	DHCP <19 years of age
<b>Allergy Testing</b>	•Covered	•Covered
<b>Bed Liners</b> (for members age 4 and up)	Covered (prior authorization is required for quantities greater than 200)	Covered (prior authorization is required for quantities greater than 200)
<b>Blood and Plasma Products</b>	•Covered	•Covered
<b>Bone Mass Measurement</b> (bone density)	Covered	Covered
<b>Behavioral Health</b> (mental health and substance abuse) - <b>outpatient</b>	•18 and above: 20 visits per fiscal year Under age 18: 30 visits per fiscal year	•30 visits per fiscal year
<b>Behavioral Health - inpatient hospitalization</b>	Covered Ages 18 and above: 30 days per fiscal year; <b>Note:</b> under age 18: covered by DSCYF (use your Medicaid ID card)	Covered by Department of Services for Children, Youth and their Families, Division of Child Mental Health (use your Medicaid ID card)
<b>Care Management</b>	Covered	Covered
<b>Chemotherapy</b>	Covered (prior authorization is required on amounts >\$250)	Covered (prior authorization is required on amounts >\$250)
<b>Colorectal/Prostate Screening Exams</b>	•Covered	•Covered
<b>CT Scans</b>	Covered	Covered
<b>Dental Services</b>	Covered by Delaware Medicaid for individuals under age 21 (use your Medicaid ID card)	Covered by Delaware Medicaid (use your Medicaid ID card)
<b>Diabetic Education</b>	•Covered	•Covered
<b>Diabetic Supplies</b> (glucose/strips)	Covered by Delaware Medicaid (use your Medicaid ID card)	Covered by Delaware Medicaid (use your Medicaid ID card)
<b>Diabetic Equipment</b> (insulin pump and supplies)	Covered (prior authorization is required on amounts >\$300 and all rentals)	Covered (prior authorization is required on amounts >\$300 and all rentals)
<b>Dialysis</b>	•Covered	•Covered
<b>Diapers</b> (for members age 4 and up)	Covered (prior authorization is required on quantities >200)	Covered (prior authorization is required on quantities >200)
<b>Drugs – given to you in a doctor’s office</b>	Covered (prior authorization is required on amounts >\$250)	Covered (prior authorization is required on amounts >\$250)
<b>Durable Medical Equipment</b>	Covered (prior authorization is required on amounts >\$300)	Covered (prior authorization is required on amounts >\$300)
<b>EPSDT Services</b> (Early and Periodic Screening, Diagnosis and Testing)	•Covered for individuals under age 21	•Covered
<b>Emergency Room Care</b>	•Covered	•Covered
<b>Emergency Medical Transportation</b> (air and ambulance)	•Covered	•Covered

• Self referred service to a participating Unison provider.

**Note:** some services may require prior authorization.

# HEALTH CARE BENEFITS

Benefit	Medicaid	DHCP <19 years of age
Eye Tests, Routine	•Covered	•Covered
Eyeglasses or Contacts	Covered (under age 21: annually; age 21 and over: every other year)	Covered (annually)
Family Planning Services **	Covered - Members may self-refer, but do not need to use a participating provider.	Covered - Members may self-refer, but do not need to use a participating provider.
Genetic Testing	Covered	Covered
Glaucoma Screening	•Covered	•Covered
Gynecology Visits	•Covered	•Covered
Hearing Exams	•Covered	•Covered
Hearing Aids and Batteries	•Covered for individuals under age 21	•Covered
HIV/AIDS Testing	•Covered	•Covered
Home Health Care and Infusion Therapy	Covered	Covered
Hospice Care	Covered	Covered
Hospitalization	Covered	Covered
Immunizations	•Covered	•Covered
Lab Tests and X-rays	•Covered	•Covered
Mammograms	•Covered	•Covered
Medical Supplies	Covered (prior authorization is required on amounts >\$300 and all rentals)	Covered (prior authorization is required on amounts >\$300 and all rentals)
Non-Participating Provider	Covered	Covered
Nursing Home	Covered	Covered
Obstetrical/Maternity Care	Covered	Covered
Orthopedic Shoes	Covered (prior authorization is required on amounts >\$300)	Covered (prior authorization is required on amounts >\$300)
Outpatient Surgery, Same Day Surgery, Ambulatory Surgical Center	Covered	Covered
Pain Management Services	•Covered	•Covered
Parenting / Child Birth Education	Covered	Covered
Personal Care (in home) / Aide Services	Covered	Covered
Podiatry Care	•Covered for routine care for members with diabetes or peripheral vascular disease only; all other podiatry visits require prior authorization	•Covered for routine care for members with diabetes or peripheral vascular disease only; all other podiatry visits require prior authorization
Prescription Drugs	Covered by Delaware Medicaid (use your Medicaid ID card)	Covered by Delaware Medicaid (use your Medicaid ID card)

• Self referred service to a participating Unison provider.

**Note:** some services may require prior authorization.

## HEALTH CARE BENEFITS

<b>Benefits</b>	<b>Medicaid</b>	<b>DHCP &lt;19 years of age</b>
<b>Primary Care Provider Visits</b>	•Covered	•Covered
<b>Private Duty Nursing</b>	Covered	Covered
<b>Prostate Cancer Screening Exams</b>	•Covered	•Covered
<b>Prosthetics and Orthotics</b>	Covered (prior authorization is required on amounts >\$300)	Covered (prior authorization is required on amounts >\$300)
<b>Radiation</b>	Covered	Covered
<b>MRI, MRA, PET Scan</b>	Covered	Covered
<b>Rehabilitation</b> (inpatient hospital)	Covered	Covered
<b>Respite</b>	Not Covered	Not Covered
<b>Skilled Nursing Facility Care</b>	Covered up to 30 days per year	Covered up to 30 days per year
<b>Sleep Apnea Studies / Sleep Therapy</b>	Covered	Covered
<b>Smoking Cessation Counseling</b>	Covered	Covered
<b>Smoking Cessation Products</b>	Covered by Delaware Medicaid (use your Medicaid ID card)	Covered by Delaware Medicaid (use your Medicaid ID card)
<b>Specialty Physician Services</b> (except specialist visits for pain management services )	•Covered	•Covered
<b>Therapy</b> (outpatient occupational, physical, speech)	Covered	Covered
<b>Transportation</b> (routine non-emergency)	Covered by Delaware Medicaid (use your Medicaid ID card) 30 one-way or 15 round trips per year	Not Covered

• Self referred service to a participating Unison provider.

**Note:** some services may require prior authorization.