

Covered Benefits

Service*	Limitations
Allergy Testing and Treatment	none
Ambulance Service (emergency)	none
Ambulance Service (non-emergency)	covered when determined to be medically necessary
Ambulatory Surgical Center / Short Procedure Unit Services	none
Blood and Blood Products	Covers whole blood and blood components, such as plasma, platelets and red packed blood cells. The administration and processing of blood are covered services as part of a covered inpatient hospital stay. The storage of blood when done in preparation for a scheduled surgical procedure and transfusion supplies and equipment are covered when part of a covered inpatient hospital stay.
Certified Registered Nurse Practitioners (CRNP)	none
Dental Services	Includes emergency, preventive and routine dental care including root canals, crowns and periodontics. Two exams per year; orthodontia and cosmetic surgery excluded.
Diabetic Retinal Eye Exams	one examination per year
Durable Medical Equipment (DME)	includes, at a minimum, equipment that: <ul style="list-style-type: none"> • is primarily and usually used to serve a medical purpose; • is generally not useful in the absence of an illness or injury; • is appropriate for use in the home or school; and • can withstand repeated use.
Eye Care	Includes emergency, preventive and routine vision care including the cost of corrective lenses and frames. One exam per year; two sets of lenses per year, maximum \$65 each; one frame per year, maximum \$60 (maximum at Wal-Mart is \$18 per frame); OR one pair soft daily-wear contacts for children 13 or older. Annual diabetic retinal examinations are also covered.
Family Planning	none
Gynecological Exams	one examination per year
Hearing Aids	one hearing aid per ear, per two years
Health Management	none

* Depending on coverage level, copays may apply for certain services under the subsidized and at-cost plans.

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Hearing Care	emergency, preventive and routine care, including the cost of examinations.
Home Health Care	limited to 60 days per year; includes professional services, intermittent skilled nursing care, physical therapy, speech therapy and other medical services and supplies when provided in conjunction with skilled services.
Hospitalization (inpatient)	up to 90 days per year, per eligible child in combination with mental health inpatient.
Hospitalization (outpatient)	none
Laboratory X-rays and Diagnostic Tests	none
Maternity Visits	none
Medical Foods and Diabetic Supplies	covered when medically necessary.
Mental Health Services (partial hospitalization)	maximum of 30 days per year; lifetime benefit of 90 days.
Mental Health Services (inpatient)	90 days per year for eligible children, in combination with medical inpatient; these days may be exchanged on a 2-to-1 basis for additional partial hospitalization services.
Mental Health Services (outpatient)	50 outpatient visits per year.
Newborn Care	Covers routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, for a period of 31 days.
Oral Surgery	<ul style="list-style-type: none"> • Accidental injury to the jaw or structures contiguous to the teeth, provided that care or treatment is sought within 24 hours of accident causing such injury. • The correction of a non-dental physiological condition which has resulted in severe functional impairment. • Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. • Removal of partially-or fully-impacted wisdom teeth.
Organ Transplants	when medically necessary
Outpatient Services	none
Pharmaceutical Services	<ul style="list-style-type: none"> • injectable medications • prescribed drugs and biologicals (formulary applies) • over-the-counter drugs (covered with prescription; limited to formulary items)
Physician Care (inpatient)	none
Primary Care Physician Services	none

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Preventive Services	Covers services including, well- and sick-child visits, immunizations, health education, tuberculosis testing and developmental screening in accordance with routine schedule of well-child visits
Rehabilitation (inpatient)	60 days per service type, per year, as long as there is significant improvement; includes physical, occupational, inhalation and speech therapy
Rehabilitation (outpatient)	60 days per service type, per year, as long as there is significant improvement; includes physical, speech and occupational therapy
Renal Dialysis	none
Skilled Nursing Facilities (SNF)	up to 90 days per year, per eligible child in combination with mental health inpatient (sum of inpatient SNF cannot exceed 90 days)
Specialists	none
Substance Abuse Treatment (inpatient detoxification)	reimbursement for each admission is limited to seven days of treatment
Substance Abuse Treatment (non-hospital residential services)	maximum of 90 days per year; lifetime benefit 360 days
Substance Abuse Treatment (outpatient)	maximum of 90 outpatient sessions per year; lifetime benefit 360 days; these days may be exchanged on a 2-to-1 basis to secure up to 15 additional non-hospital residential treatment days
Therapy	limited to physical, occupational, inhalation and speech therapy
Tobacco Cessation Classes	none