

HEALTH CARE BENEFITS

Benefits (subject to Unison policies and procedures)	Benefit Package E-01 children under 21	Benefit Package E-02 categorically needy	Benefit Package E-03 general assistance	Benefit Package E-04 medically needy	Benefit Package E-05 general assistance
Abortion	Covered* (under certain circumstances; consent form required)	Covered* (under certain circumstances; consent form required)	Covered* (under certain circumstances; consent form required)	Covered* (under certain circumstances; consent form required)	Covered* (under certain circumstances; consent form required)
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Allergy Testing	Covered**	Covered**	Covered**	Covered**	Covered**
Ambulance Emergency Medical Transportation	Covered	Covered	Covered	Covered	Covered
Ambulance Non-Emergency Medical Transportation	Covered (age 18 & older. copay applies: \$1 per trip)	Covered (copay applies: \$1 per trip)	Covered (copay applies: \$1 per trip)	Covered (copay applies: \$1 per trip)	Covered (copay applies: \$1 per trip)
Behavioral Health (mental health & substance abuse)	Covered by county or behavioral health plan	Covered by county or behavioral health plan	Covered by county or behavioral health plan	Covered by county or behavioral health plan	Covered by county or behavioral health plan
Blood & Plasma Products	Covered*	Covered*	Covered*	Covered*	Covered*
Bone Mass Measurement (bone density)	Covered**	Covered**	Covered**	Covered**	Covered**

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Case Management	Covered	Covered	Covered	Covered	Covered
Chiropractor Services	Covered*	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)	Covered (maximum of 18 doctor visits combined per year, from July 1 – June 30)
Colorectal/ Prostate Screening Exams	Covered**	Covered**	Covered**	Covered**	Covered**
Dental Services	Covered (Includes full dental services)	Covered (Includes full dental services)	Covered (limited to cleanings, exams, x-rays every 6 months, simple extractions & fillings)	Covered (limited to cleanings, exams, x-rays every 6 months, simple extractions & fillings)	Covered (limited to cleanings, exams, x-rays every 6 months, simple extractions & fillings)
Diabetic Education	Covered	Covered (10 visits per year, from July 1 – June 30)	Covered (10 visits per year, from July 1 – June 30)	Covered (10 visits per year, from July 1 – June 30)	Covered (10 visits per year, from July 1 – June 30)
Diabetic Supplies & Equipment	Covered (Some items may require prior authorization. Age 18 & older; copay applies: \$1 per item, up to \$3.)	Covered (Some items may require prior authorization. Copay applies: \$1 per item, up to \$3.)	Covered (Some items may require prior authorization. Copay applies: \$1 per item, up to \$6.)	Covered (Some items may require prior authorization. Copay applies: \$1 per item, up to \$3.)	Covered (Some items may require prior authorization. Copay applies: \$1 per item, up to \$6.)
Dialysis	Covered (member may self-refer)	Covered (member may self-refer)	Not Covered	Covered (member may self-refer)	Not Covered

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Durable Medical Equipment	Covered** (Prior Authorization required if greater than \$300. Age 18 & older; copay applies for purchase items: \$1 per item, up to \$3.)	Covered** (Prior Authorization required if greater than \$300. Copay applies for purchase items: \$1 per item, up to \$3.)	Not Covered (Unless you are also getting home health at the same time*; copay applies for purchase items: \$1 per item, up to \$6.)	Not Covered (Unless you are also getting home health at the same time*; copay applies for purchase items: \$1 per item, up to \$3.)	Not Covered (Unless you are also getting home health at the same time*; copay applies for purchase items: \$1 per item, up to \$6.)
EPSDT (Early and Periodic Screening and Diagnostic Testing) Services/ Immunizations	Covered	Not Covered	Not Covered	Not Covered	Not Covered
Emergency Room Care	Covered	Covered	Covered	Covered	Covered
Eye Tests, Routine	Covered (member may self- refer to participating provider)	Covered (member may self- refer to participating provider)	Covered (member may self- refer to participating provider)	Covered (member may self- refer to participating provider)	Covered (member may self- refer to participating provider)
Family Planning Services	Covered (member may self-refer to any family planning provider)	Covered (member may self-refer to any family planning provider)	Covered (member may self-refer to any family planning provider)	Covered (member may self-refer to any family planning provider)	Covered (member may self-refer to any family planning provider)
Hearing Aids & Batteries	Covered (age 18 and older; copay applies; \$1 per item, up to \$3.)	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Exams	Covered**	Covered**	Covered**	Covered**	Covered**

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HIV/AIDS Testing	Covered	Covered	Covered	Covered	Covered
Home Health Care	Covered*	Covered*	Covered* (30 visits per year from July 1 – June 30)	Covered*	Covered* (30 visits per year from July 1 – June 30)
Hospice Care	Covered*	Covered*	Covered*	Covered*	Covered*
Immunizations	Covered	Flu Vaccine Covered	Flu Vaccine Covered	Flu Vaccine Covered	Flu Vaccine Covered
Infertility Testing & Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Inpatient Hospitalization (acute)	Covered* (age 18 and older; copay applies: \$3 per day, up to \$21 maximum per stay)	Covered* (Copay applies: \$3 per day, up to \$21 maximum per stay)	Covered* (one stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay)	Covered* (Copay applies: \$3 per day, up to \$21 maximum per stay)	Covered* (one stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay)
Lab Tests & X-rays	Covered** (age 18 and older; copay applies to portable x-rays: \$1 per service)	Covered** (copay applies to portable x-rays: \$1 per service)	Covered** (copay applies to portable x-rays: \$1 per service)	Covered** (copay applies to portable x-rays: \$1 per service)	Covered** (copay applies to portable x-rays: \$1 per service)

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Mammograms (screening)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)
Obstetrical/ Maternity Care	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)
Organ Transplant Evaluation	Covered*	Covered*	Covered*	Covered*	Covered*
Organ Transplant	Covered*	Covered*	Covered*	Covered*	Covered*
Orthodontia	Covered*	Not Covered	Not Covered	Not Covered	Not Covered
Orthopedic Shoes	Covered* (age 18 and older; copay applies: \$1 per item, up to \$3.)	Covered* (copay applies: \$1 per item, up to \$3.)	Not Covered (unless you are also getting home health at the same time. Copay applies for purchase items*: \$1 per item, up to \$6.)	Not Covered (unless you are also getting home health at the same time. Copay applies for purchase items*: \$1 per item, up to \$3.)	Not Covered (unless you are also getting home health at the same time. Copay applies for purchase items*: \$1 per item, up to \$6.)
Outpatient Surgery, performed at an Ambulatory Surgical Center or Short Procedure Unit	Covered* (age 18 and older; Copay applies: \$1 per stay, up to \$3)	Covered* (Copay applies: \$1 per stay, up to \$3)	Covered* (Copay applies: \$1 per stay, up to \$6)	Covered* (Copay applies: \$1 per stay, up to \$3)	Covered* (Copay applies: \$1 per stay, up to \$6)

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Pain Management Services	Covered*	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)	Covered* (maximum of 18 doctor visits combined per year, from July 1 – June 30.)
Pap Smears and Pelvic Exams	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)
Personal Care (in-home)/ Aide Services	Covered (if related to EPSDT screening)	Not Covered	Not Covered	Not Covered	Not Covered
Podiatry Care – Medically Necessary	Covered**	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30)
Prescription Drugs	Covered (follow Drug formulary; age 18 & older; copay brand \$3; copay generic is \$1.)	Covered (follow Drug formulary; excludes medication for symptomatic relief of cough and cold; copay brand \$3; copay generic is \$1.)	Covered (6 prescriptions per month; Prilosec & Loratidine over the counter; Drug formulary; excludes medication for symptomatic relief of cough and cold; copay brand \$3; copay generic is \$1.)	Limited to birth control drugs	Limited to birth control drugs
Primary Care Physician	Covered	Covered	Covered	Covered	Covered

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Private Duty Nursing	Covered*	Not Covered	Not Covered	Not Covered	Not Covered
Prosthetics & Orthotics	Covered** (prior authorization required if greater than \$300. Age 18 & older; copay applies: \$1 per item, up to \$3.)	Covered** (prior authorization required if greater than \$300. Copay applies: \$1 per item, up to \$3.)	Not Covered (unless you are already getting home health at the same time.* Copay applies: \$1 per item, up to \$6.)	Not Covered (unless you are already getting home health at the same time.* Copay applies: \$1 per item, up to \$3.)	Not Covered (unless you are already getting home health at the same time.* Copay applies: \$1 per item, up to \$6.)
Radiation/ Chemotherapy	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)	Covered (member may self-refer)
Radiology Scans (MRI, MRA, PET)	Covered*	Covered*	Covered*	Covered*	Covered*
Rehabilitation (inpatient hospital)	Covered* (age 18 and older; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$3 per day, up to \$21 maximum per stay.)	Covered* (One stay per year, from July 1-June 30; copay applies: \$6 per day, up to \$42 maximum per stay.)
Rehabilitation (outpatient occupational, physical and speech therapy)	Covered* (age 18 and older; copay applies: \$1 per therapy visit, up to \$3.)	Covered* (Copay applies: \$1 per therapy visit, up to \$3.)	Covered* (Copay applies: \$1 per therapy visit, up to \$6.)	Covered* (Copay applies: \$1 per therapy visit, up to \$3.)	Covered* (Copay applies: \$1 per therapy visit, up to \$6.)
Skilled Nursing Facility Care	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)	Covered* (for 30 continuous days)

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Sleep Apnea Studies	Covered*	Covered*	Covered*	Covered*	Covered*
Specialty Physician Services (except OB/GYN which member may self-refer)	Covered**	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)	Covered** (maximum of 18 doctor visits combined per year, from July 1-June 30.)
Tobacco Cessation Counseling	Covered	Covered	Covered	Covered	Covered
Tobacco Cessation Products	Covered (age 18 and older; copay brand \$3; copay generic is \$1.)	Covered (copay brand \$3; copay generic is \$1.)	Covered (counted in 6 prescriptions per month limit; copay brand \$3; copay generic is \$1.)	Not Covered	Not Covered
Vision	Covered (twice per year: exams, standard eyeglass lenses or daily wear contact lenses; plus in-plan frames covered in full 4 lenses/2 frames per year \$125.00 total allowance; if vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected. Medically necessary exception to eyeglass limitations can be made for MA recipients under age 21 if needed.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)	Covered (once per year: exam, standard eyeglass lenses or daily wear contact lenses; \$125.00 total allowance; in-plan frames covered in full. If vision provider does not carry in-plan frames a \$20 allowance will apply toward frames selected.)

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