P R O V I D E R B U L L E T I N

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To: All Indiana Medical Assistance Programs Providers

Subject: Hoosier Healthwise Package C Overview Bulletin

Overview

The purpose of this bulletin is to introduce providers to an expansion of the Indiana Health Coverage Programs, formerly referred to as the Indiana Medical Assistance Programs, which will go into effect on January 1, 2000. There will be a new benefit package, which will be referred to as Hoosier Healthwise Package C – Children's Health Plan, that will provide age appropriate preventive, primary and acute care services to approximately 40,000 uninsured children statewide. The Office of Medicaid Policy and Planning (OMPP) and the Office of Children's Health Insurance Program (CHIP Office) will be using the introduction of this new benefit package as an opportunity to restructure the Medicaid program and ensure that all eligible Hoosiers enroll.

This bulletin includes the following information:

- Introduction to the Indiana Health Coverage Programs
- Overview of the programs and their benefit packages
- Overview of the three delivery systems
- Review of Hoosier Healthwise Package A: Standard Plan
- Review of Hoosier Healthwise Package B: Pregnancy Coverage Only
- Review of Hoosier Healthwise Package C: Children's Health Plan
- Review of Hoosier Healthwise Package D: Hoosier Healthwise for Persons with Disabilities or Chronic Illnesses
- Review of Hoosier Healthwise Package E: Emergency Services Only

Indiana has had great success with welfare reform, decreasing significantly the number of families requiring social assistance. Many jobs, however, do not provide benefits or provide health coverage that is not affordable for these families. Thus, Indiana, and the rest of the country, has begun to recognize medical assistance programs as health insurance rather than social assistance.

The OMPP and the CHIP Office are dedicated to minimizing the effect of these changes on the provider community and ensuring a smooth implementation of the new ***Indiana Health Coverage Programs***. Providers will be informed of activities surrounding these changes in a series of bulletins. This is bulletin number one in the series.

> *Please note: The Indiana Medical Assistance Provider Manual will now be referred to as the Indiana Health Coverage Programs Provider Manual.*

Introduction to the Indiana Health Coverage Programs

Effective January 1, 2000, the Indiana Medical Assistance Programs will be referred to as the ***Indiana Health Coverage Programs.*** With this new name, the OMPP and the CHIP Office have categorized all covered benefits into three distinct programs:

- 590
- Traditional Medicaid
- Hoosier Healthwise

Additionally the term Hoosier Healthwise will no longer refer exclusively to the managed care programs. This term has been broadened to encompass not only the various managed care components, but many other Indiana Health Coverage Programs benefit packages. These changes will be discussed in detail throughout this bulletin.

Overview of the Programs and Benefit Packages

The purpose of this section is to introduce and provide a high level overview of the three programs that constitute the Indiana Health Coverage Programs and the associated benefit packages.

590 Program Benefit Package

The 590 Program allows for the processing and payment of claims to providers for services provided off site to individuals who are residents of state owned facilities under the direction of the Family and Social Services Administration (FSSA) Division of Mental Health (DMH), and the Indiana State Department of Health (ISDH).

Individuals enrolled in the 590 Program are eligible for the full array of benefits covered under the Indiana Health Coverage Programs. Eligibility for the 590 Program may be determined using the Eligibility Verification System.

Providers must be enrolled in the 590 Program in order to receive reimbursement for services rendered to members in this program. Services provided to individuals enrolled in the 590 Program will be reimbursed by the program when the billed amount is greater than $150. Additionally, all services totaling $500 or more require prior authorization. The following table provides a brief outline of covered services.

Table 1. 1 – 590 Program Benefit Package

Benefit Package	Coverage
590	Members residing in state owned facilities under the direction of the Family and Social Services Administration (FSSA) Division of Mental Health (DMH), and the Indiana State Department of Health (ISDH).

Traditional Medicaid Program Benefit Packages

The Traditional Medicaid program provides services to aged, blind and disabled individuals. The benefit packages associated with Traditional Medicaid are as follows:

- **Standard Plan** – Provides full benefits to enrolled members.
- **Spenddown** – Some individuals with income in excess of the Medicaid threshold can still be enrolled in Medicaid. These recipients are enrolled with a spenddown. Spenddown recipients must incur medical expenses in the amount of their excess income each month before becoming eligible for Medicaid. Once spenddown is met for the month, the individual is eligible for full Medicaid benefits for the remainder of the month.
- **Waivered Services** – Some disabled individuals are eligible for enhanced services through a federally approved waiver. These

services are in addition to the full benefits provided under the standard Medicaid plan.

Qualified Medicare Beneficiaries (QMB) – For members enrolled as a QMB, coverage is limited to payment of Medicare Part B premiums, deductibles and co-insurance. Non-covered Medicaid services are not reimbursable by Medicaid.

A QMB enrolled member can also be enrolled in Medicaid with a spenddown. In these situations, until spenddown has been met for the month, the member is eligible for coverage as a QMB.

The following table provides a brief outline of covered services.

Table 1. 2 – Traditional Medicaid Program Benefit Packages

Benefit Package	Coverage
Standard Plan – For the Aged, Blind and Disabled	Provides full coverage Additional Considerations: • *Includes all spenddown members* • *Includes all waiver program services except Medically Fragile Child Waiver*
Qualified Medicare Beneficiaries (QMB)	Coverage is limited to payment of Medicare Part B premiums, deductibles and co-insurance. Members may also be enrolled in Medicaid with a spenddown.

Hoosier Healthwise Program and Benefit Packages

The Hoosier Healthwise program will provide coverage to children, pregnant women and low-income families. The term "Hoosier Healthwise" will no longer refer exclusively to the managed care programs. On January 1, 2000, Hoosier Healthwise will be expanded and redefined as follows:

Table 1.3–Hoosier Healthwise Benefit Packages

Benefit Package	Coverage
Package A – Standard Plan	Full coverage for children, low-income families, and some pregnant women
Package B – Pregnancy Coverage Only	Pregnancy-related and urgent care services for some pregnant women
Package C – Children's Health Plan	Preventive, primary and acute care services for some children aged 18 and under
Package D – Hoosier Healthwise for People with Disabilities (HHPD) and Chronic Illnesses	Full coverage with case management services
Package E – Emergency Services Only	Individuals enrolled in this package are eligible for emergency services only

Overview of the Three Delivery Systems

One of the most important questions in regard to the new Indiana Health Coverage Programs is, "How will providers be reimbursed for services rendered to members enrolled in one of the three programs?" For the most part, billing policies and procedures will not undergo any changes on January 1, 2000. The three delivery systems remain the same and are as follows:

- Fee-for-Service
- Primary Care Case Management (PCCM)
- Risk Based Managed Care (RBMC)

Fee-For-Service Delivery System

The fee-for-service delivery system reimburses providers on a per service basis. Essentially, providers bill services rendered to members in programs which are subject to fee-for-service directly to EDS, the claims processing contractor. Reimbursement for the Indiana Health Coverage Programs is made according to one of the following methodologies:

- Resource Based Relative Value System (RBRVS)
- Statewide Established Max Fee/Manual Pricing
- Diagnosis Related Grouping (DRG)
- Institutional Per Diem

Fee-for-service reimbursement may apply to individuals enrolled in any one of the Indiana Health Coverage Programs benefit packages. Providers will have to consult the Eligibility Verification System to determine which delivery system is applicable. When verifying eligibility, in the absence of PCCM and RBMC indicators, providers should expect to be reimbursed under the fee-for-service delivery system. Primary Medical Provider (PMP) authorization is not required for services provided to members enrolled in the fee-for-service delivery system.

Primary Care Case Management (PCCM) Delivery System

The Primary Care Case Management (PCCM) delivery system is available statewide. It is a fee-for-service arrangement where providers submit claims to EDS for payment. The Primary Medical Provider (PMP) authorizes many of the services that the member requires.

Under the PCCM delivery system, the PMP is the primary source for medical care and referral services for eligible members. These PMPs serve as the member's healthcare 'gatekeeper' for most preventive, treatment, consultative, and follow-up medical care. The Indiana Health Coverage Programs will reimburse the PMP for primary care services rendered at the current statewide allowable amount plus an additional $3 administrative fee (on a per member, per month basis).

To be eligible as a PMP, a physician (M.D. or D.O.) must provide primary care services as a solo practitioner or within a physician group practice/clinic as one of the following provider types:

- General Practitioner
- Family Practitioner
- General Pediatrician
- General Internist
- Obstetrician/Gynecologist

The PMP must authorize all non-emergency hospital admissions for members enrolled in the PCCM delivery system. The PMP authorization of an inpatient hospital stay covers all components of the inpatient hospitalization—no additional authorization is required for inpatient hospital services.

The following services do NOT require PMP authorization:

- Chiropractic
- Pharmacy
- Podiatry
- Emergency
- Vision care
- HIV case management
- Transportation
- Family planning
- Dental (submitted on a dental claim form) – except in an acute care setting
- Mental health (by type and specialty)
- Individualized educational programs

Risk Based Managed Care Delivery System

In the Risk-Based Managed Care (RBMC) delivery system, the State contracts with Managed Care Organizations (MCOs) in each region to provide Indiana Health Coverage Programs covered services to enrolled Hoosier Healthwise members.

The State of Indiana is divided into three geographic regions:

- Northern
- Central
- Southern

The State has contracted with Maxicare as the MCO in the Northern, Central, and Southern regions. Maxicare has named its Hoosier Healthwise MCO MaxiHealth. The State of Indiana has contracted with another MCO in the Central Region, Managed Health Services (MHS).

The MCOs are paid a capitation fee (per member, per month), to provide covered services to enrolled members. The MCOs then negotiate payment arrangements with their network of providers. Under certain circumstances, and for certain services, including dental services provided in an inpatient/outpatient setting or an ambulatory surgical center (ASC), non-network providers may provide services to the MCOs' members. In these instances, the MCOs pay the non-network provider on a fee-for-service basis in accordance with the Indiana Health Coverage Programs fee schedule.

All providers that render services covered by the MCOs to a Hoosier Healthwise member enrolled in RBMC should submit all claims for reimbursement directly to the MCO in which the member is enrolled with two exceptions. If the provider does not have an agreement with the MCO in which the member is enrolled, the provider risks denial of payment if he/she provides service.

The following services are NOT billed to the MCO:

- Mental health (by type and specialty)
- Dental (except in an acute care setting)

Services that do NOT require PMP authorization (or self referral):

- Dental services (except in an acute care setting)
- Family planning
- Chiropractic
- Podiatrist
- Vision care (except surgery)
- HIV/Case management
- Treatment of a true emergency

Any claim for reimbursement of services covered by the MCO for a Hoosier Healthwise member enrolled in RBMC that is submitted to EDS will be denied.

Providers are reminded that questions and/or concerns regarding policies on claims submission, processing, reimbursements, and covered services should be directed to the MCO in which the member is enrolled. The following table includes MCO contact information.

Table 1.4 MCO Contact Information

MCO Area	Contact Information
RBMC Central Region	MaxiHealth Central Member Services 1-800-401-6294 MaxiHealth Central Region Provider Services 1-800-360-6294 MHS UM/Case Management/Referrals 1-800-464-0991 MHS Case Management Fax Number (317) 684-8011 MHS NurseWise Hotline 1-800-431-4084

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Table 1.4 MCO Contact Information (Continued)

MCO Area	Contact Information
RBMC Southern Region	MaxiHealth Southern Region Member Services MaxiHealth Southern Region Pharmacy MaxiHealth Southern Region Eligibility Verification MaxiHealth Southern Region Claims Status/Payment 1-800-414-5946 MaxiHealth Southern Region Provider Services 1-800-266-0290 MaxiHealth Southern Region UM/Case Management 1-800-266-0988 MaxiHealth Southern Region Referral Authorization 1-800-464-0991 MaxiHealth Southern Region Transportation 1-800-355-2668 MaxiHealth Southern Region After Hours Hotline 1-800-431-4084 MaxiHealth Southern Region Case Management Fax 1-812-473-2711

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Table 1.4 MCO Contact Information (Continued)

MCO Area	Contact Information
RBMC Northern Region	MaxiHealth Northern Region Member Services MaxiHealth Northern Region Pharmacy MaxiHealth Northern Region Eligibility Verification MaxiHealth Northern Region Claims Status/Payment 1-800-414-5946 MaxiHealth Northern Region Provider Services 1-800-414-9475 MaxiHealth Northern Region UM/Case Management 1-800-414-9475 MaxiHealth Northern Region Referral Authorization 1-800-464-0991 MaxiHealth Northern Region Transportation 1-800-355-2668 MaxiHealth Northern Region After Hours Hotline 1-800-431-4084 MaxiHealth Northern Region Case Management Fax 1-219-756-2077

Dental Services in Risk-Basked Managed Care (RBMC)

Effective August 1, 1998, dental provider services billed on dental claim forms are excluded from RBMC. Providers should submit dental claims incurred by managed care members (members of either MHS or MaxiHealth) with dates of service on or after August 1, 1998, to EDS for adjudication. Dental claims for dates of service prior to August 1, 1998 are to be submitted to the appropriate MCO.

Providers should be aware that services rendered in an inpatient/ outpatient or ASC setting to an enrollee in the PCCM delivery system must be authorized by the PMP.

Overview of Hoosier Healthwise Benefit Packages

Hoosier Healthwise Package A: Standard Plan

Standard Plan coverage encompasses the full array of Indiana Health Coverage Programs benefits for children, pregnant women, and low-income families enrolled in the Hoosier Healthwise program.

For members enrolled in Hoosier Healthwise Package A, billing policies and procedures will not undergo any changes on January 1, 2000.

Hoosier Healthwise Package B: Pregnancy Coverage Only

Pregnancy coverage includes:

- Prenatal care
- Delivery
- Postpartum
- Family planning services
- Pharmacy
- Transportation
- Treatment of conditions which may complicate the pregnancy. This is defined as a service provided to a pregnant woman after the onset of a medical condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the member's condition, or a need for a higher level of care.

Billing policies and procedures will not undergo any changes on January 1, 2000, for members enrolled in Hoosier Healthwise Package B.

Special care must be taken to use a diagnostic code which relates to the pregnancy or complications of the pregnancy, or when applicable, to check "emergency" on the claim form, when billing for covered services.

Hoosier Healthwise Package C: Children's Health Plan

Hoosier Healthwise Package C will provide preventative, primary and acute health care coverage to children less than 19 years of age.

Criteria for Eligibility

To be eligible a child must meet the following criteria:

- The child must be less than 19 years of age;
- The child's family income must be between 150 and 200 percent of the Federal poverty level;
- The child must not have credible health insurance at any time during the three month period prior to applying for the Hoosier Healthwise program; and
- The child's family must satisfy all cost-sharing requirements.

Enrollment Process and Cost Sharing Requirements

Package C will have the same application process as the other Hoosier Healthwise benefit packages.

If a child is determined eligible for Package C, he or she will be made conditionally eligible pending a premium payment. The child's family will have the option of paying the premium on a monthly, quarterly or annual basis. Only after the premium is paid will actual eligibility information be transferred to the Indiana*AIM* system. The following table illustrates the premium payment requirements.

Table 1.5 Premium Payment Requirements

Premiums						
Income (As a Percentage of the Federal Poverty Level)	**Monthly**		**Quarterly**		**Annually**	
	One Child	**Two or More**	**One Child**	**Two or More**	**One Child**	**Two or More**
150 to 175 percent	$11	$16.50	$31.50	$47.25	$120	$180
175 to 200 percent	$16.50	$24.75	$47.25	$71	$180	$270

Enrollment will continue as long as premium payments are received and the child continues to meet the other eligibility requirements. Enrollment will be terminated for non-payment of premiums after a 60 day grace period.

Members' families will also be required to make copayments for some services. Providers will be responsible for collecting copayments and the copayment amount will be deducted from the claim. The following

table describes the copayments required and the corresponding copayment amount.

Table 1.6 Description of Copayments

Service	Copayment
Prescription drugs-generic, compound and sole-source	$3
Prescription drugs-brand name	$10
Ambulance Transportation	$10
Emergency room visit that does not result in hospitalization	$20

Package C and Retroactive Eligibility

Eligibility for Traditional Medicaid and any other Hoosier Healthwise benefit package can be established retroactively up to three months prior to a member's date of application. Thus, if it is determined that a Package C member is retroactively eligible for any other benefit package, providers who have rendered services to Package C members during a period of retroactive eligibility are bound by the following requirements.

- Payment for services that were not covered by Package C and were paid for by the Package C member, but are covered by the benefit package for which the member is now eligible must be refunded immediately to the member. However, if your normal practice-management protocols specify standard refund procedures, and those refund procedures are applied to all refunds regardless of member status, refunds to Indiana Health Coverage Programs members may be handled in the standard manner dictated by your practice-management protocols.
- The provider must then bill the Indiana Health Coverage Programs for the covered service.
- If prior authorization is required for the covered service under the new benefit package, it may be requested retroactively up to one year from the date the member was enrolled.

Package C members do not have up to three months of retroactive eligibility. Package C members are eligible for coverage beginning the month of application for Hoosier Healthwise.

Coverage

Benefits offered through Hoosier Healthwise Package C will focus on age-appropriate preventive, primary and acute care services for children.

Children enrolled in Package C are eligible for the following benefits:

- Hospital services
- Clinic services
- Laboratory and radiology services
- Early intervention services
- Physicians' surgical and medical services
- Podiatry
- Vision services
- Chiropractic services
- Home health services
- Medical supplies and equipment
- Dental services
- Therapies
- Prescription drugs
- Inpatient rehabilitative services
- Mental health/substance abuse services
- Hospice care
- Ambulance transportation

The following services have coverage limitations under Hoosier Healthwise Package C that differ from those limitations required by Hoosier Healthwise Package A:

Early intervention services – Package C covers immunizations, and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the Package C benefit limitations.

Podiatry services – Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary.

Chiropractic services – Coverage is limited to five visits and 14 therapeutic physical medicine treatments per member per year. Additional treatments may be covered if prior authorization is obtained based on medical necessity.

Medical supplies and equipment – Coverage is available for a maximum benefit of $2,000 per year and $5,000 per lifetime per member.

Therapies – Physical, speech, occupational, and respiratory therapy is covered for a maximum of 50 visits per year, per type of therapy.

Prescription drugs – Pharmacists may substitute the generic equivalent of a brand name drug only when the prescribing physician has indicated on the written or orally communicated prescription that the generic equivalent may be substituted. If the prescribing physician has indicated that the medication should be dispensed as written, the pharmacist must dispense the drug prescribed.

Inpatient rehabilitative services – Coverage is available for a maximum of 50 days per calendar year.

Mental health/substance abuse services – Coverage for outpatient office visits is limited to a maximum of 30 per year, per member, without prior authorization to a maximum of 50 visits per year. Inpatient services are covered when medically necessary except when they are provided in an institution for mental diseases with more than 16 beds.

The following medical services are not covered by Hoosier Healthwise Package C:

- Nursing facility services
- Private duty nursing
- Community mental health rehabilitation
- Intermediate care facilities for the mentally retarded
- Case management for persons with HIV
- Case management for pregnant women
- Case management for mentally ill or emotionally disturbed
- Non-ambulance transportation
- Christian science nurses

- Christian science sanatoriums
- Organ transplants
- Over-the-counter medications (except insulin)
- Bed reservations in psychiatric hospitals

Please consult Appendix A – Hoosier Healthwise Benefit Package Comparison for additional information regarding coverage limitations and non-covered services.

Wrap-around Services

Children enrolled in Hoosier Healthwise Package C may be eligible for additional health coverage from the following programs:

Indiana First Steps – First Steps provides early intervention services, including screenings and assessments, planning and service coordination, therapeutic services, support services, and information and communication, to infants and toddlers with disabilities or who are developmentally vulnerable.

Children's Special Health Care Services (CSHCS) – The CSHCS program provides health care services for children through age 21 who have a severe, chronic medical condition which has lasted, or is expected to last at least two years; will produce disability, disfigurement, or limits on function; requires special diet or devices; or without treatment would produce a chronic disabling condition.

Both programs require the assistance of health care professionals to identify children for assessment and diagnostic evaluations, and to provide diagnoses and referrals. Additional information about the programs may be obtained by calling First Steps at 1-800-441-STEP (7837) and by calling CSHCS at 1-800-475-1355.

Provider Enrollment

Providers currently enrolled in the Indiana Health Coverage Programs will not be required to complete a separate Provider Enrollment Application or special program addendum for the Hoosier Healthwise Package C members.

Billing Considerations

The billing procedures for Hoosier Healthwise Package C will be the same as those for the other Hoosier Healthwise benefit packages.

Pharmacists may substitute the generic equivalent of a brand name drug only when the prescribing physician has indicated on the written or orally communicated prescription that the generic equivalent may be substituted. If the prescribing physician has indicated that the medication should be dispensed as written, the pharmacist must dispense the drug prescribed.

Even though children enrolled in Hoosier Healthwise Package C should not have other credible health coverage, providers are required to bill all other insurance carriers prior to billing the Indiana Health Coverage Programs if additional insurance coverage is discovered.

The following table represents Explanation of Benefit (EOB) codes associated with denied claims for non-covered services rendered to members enrolled in Hoosier Healthwise Package C. Providers can expect to encounter these EOB codes beginning January 1, 2000. Additional EOB codes associated with Hoosier Healthwise Package C will be introduced in the second quarter of 2000.

Table 1.7 Explanation of Benefit Codes

Edit Codes for Package C	
Code	**Description**
2033	Package C client not eligible for claim type
4062	Organ transplants are non-covered for Package C. Please verify and resubmit.
4082	Bed reservations rendered in an institution for mental health diseases are a non-covered service for Package C.
4083	Inpatient care rendered in an institution for mental health diseases are non-covered for Package C.
4126	Over-the-counter and non-legend drugs are non-covered for Package C.

Hoosier Healthwise Package D: Hoosier Healthwise for Persons with Disabilities and Chronic Illnesses

The Hoosier Healthwise Program for persons with disabilities and chronic illnesses (HHPD) is a voluntary program available only in Marion County. Managed Health Services (MHS) is the Managed Care Organization (MCO) that the State has contracted with to administer

the HHPD benefit package. MHS has named its HHPD health plan "Team*Select*".

The HHPD benefit package has been designed to insure that members receive primary, specialty and preventative healthcare through a comprehensive, coordinated approach. This approach includes a wellness plan. The plan is developed by a wellness team which includes:

- The member and his/her family member
- Friend or care provider
- The member's primary medical provider (PMP)
- A Team*Select* Personal Care Coordinator (case manager)
- Specialist(s)

Services rendered to members enrolled in the Hoosier Healthwise Package D are the financial responsibility of MHS/Team*Select*. Accordingly, **claims for all Package D covered services rendered to HHPD members must be submitted to MHS/Team*Select,* as opposed to EDS**. MHS/Team*Select's* billing address and provider/member services telephone number are as follows:

Managed Health Services/Team*Select*

P.O. Box 2910

Milwaukee, WI 53201-2910

Provider/Member Services

1-888-218-9014 (toll free)

1-317-630-7636

Dental services are "carved-out" from MCO services and are billed directly to EDS. Mental health services are NOT carved-out (or excluded) from the HHPD benefit package. The MCO is responsible for payment of all mental health services in the HHPD benefit package only.

Hoosier Healthwise Package D in Marion County will end on December 31, 1999. The OMPP is evaluating Package D for possible future implementation statewide.

Hoosier Healthwise Package E: Emergency Services Only

Health coverage for certain members is limited to treatment for medical emergency conditions. The Omnibus Budget Reconciliation

Act of 1986 defines an *Emergency Medical Condition* as *a medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part.*

In the case of pregnant women eligible for coverage under Hoosier Healthwise Package E, labor and delivery services are also considered emergency medical conditions.

Emergency billing policies and procedures will **not** undergo any changes on January 1, 2000.

For services rendered to members enrolled in this benefit package, providers must indicate "emergency" in the proper form locator on the claim form. The following table provides specific billing instructions for claims associated with services rendered to Hoosier Healthwise Package E members.

Table 1.8 Hoosier Healthwise Package E Billing Instructions

Claim Form	Location
HCFA 1500 Claim Form	Field Number 24I: • *Enter "Y" for Yes* • *Enter "N" for No*
UB 92 Claim Form	Form Locator 19: • *Enter "1" for Emergency*

Appendix A: Hoosier Healthwise Benefit Package Comparison

Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Inpatient Hospital Services*	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. See Covered Services and Limitations Rule 405 IAC 5.	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. See Covered Services and Limitations Rule 405 IAC 5.	Emergency inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's acute condition. See Covered Services and Limitations Rule 405 IAC 5.
Outpatient Hospital Services*	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. See Covered Services and Limitations Rule 405 IAC 5.	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition. See Covered Services and Limitations Rule 405 IAC 5.	Emergency outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's acute condition. See Covered Services and Limitations Rule 405 IAC 5.

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Rural Health Clinics	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	Reimbursement available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	
Federally Qualified Health Centers (FQHCs)	Reimbursement available for medically necessary services provided by licensed health care practitioners.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement available for medically necessary services provided by licensed health care practitioners.	Reimbursement available for medically necessary services provided by licensed health care practitioners.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Laboratory and Radiology Services	Must be ordered by a physician.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), and conditions which may complicate the pregnancy or urgent care services.	Must be ordered by a physician.	Must be ordered by a physician.	
Nurse Practitioners	Reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	
Nursing Facility Services**	Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services and conditions which may complicate the pregnancy or urgent care services.		Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Early Intervention Services	Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the HealthWatch EPSDT periodicity and screening schedule.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covers immunizations, and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the CHIP benefit package coverage limitations.	Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the HealthWatch EPSDT periodicity and screening schedule.	
Family planning services and supplies	Provided with limitations. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Provided with limitations. See Covered Services and Limitations Rule 405 IAC 5.	Provided with limitations. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Physicians' surgical and medical services*	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per year per member without prior authorization. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per year per member without prior authorization. See Covered Services and Limitations Rule 405 IAC 5.	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per year per member without prior authorization. See Covered Services and Limitations Rule 405 IAC 5.	
Nurse-midwife services	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Reimbursement is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Podiatrists	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. Routine foot care services are not covered.	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.	
Vision Services	Reimbursement for the initial vision care examination will be limited to one examination per year for a member under 19 years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement for the initial vision care examination will be limited to one examination per year for a member under 19 years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.	Reimbursement for the initial vision care examination will be limited to one examination per year for a member under 19 years of age unless more frequent care is medically necessary. Optical supplies covered when prescribed by ophthalmologist or optometrist.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Eyeglasses	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen, or broken beyond repair through no fault of the member. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen, or broken beyond repair through no fault of the member. See Covered Services and Limitations Rule 405 IAC 5.	Reimbursement for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen, or broken beyond repair through no fault of the member. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Chiropractors*	Reimbursement is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member per year.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 14 therapeutic physical medicine treatments per member per year. Additional treatments may be covered if prior approval is obtained based on medical necessity.	Reimbursement is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member per year.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Home Health Services**	Reimbursement is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Reimbursement is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals. See Covered Services and Limitations Rule 405 IAC 5.	Reimbursement is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)**	Reimbursement is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covered when medically necessary. Maximum benefit of $2,000 per year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased depending on which is more cost-efficient.	Reimbursement is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary. See Covered Services and Limitations Rule 405 IAC 5.	
Dental Services	In accordance with Federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	All medically necessary dental services are provided for children enrolled in Package C even if the service is not otherwise covered under CHIP. See Covered Services and Limitations Rule 405 IAC 5.	In accordance with Federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Physical Therapy**	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for initial evaluations, or for services provided within 30 days following discharge from hospital when ordered by physician prior to discharge. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for initial evaluations, or for services provided within 30 days following discharge from hospital when ordered by physician prior to discharge. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Speech, Hearing and Language Disorders*	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for initial evaluations, or for services provided within 30 days following discharge from hospital when ordered by physician prior to discharge. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for initial evaluations, or for services provided within 30 days following discharge from hospital when ordered by physician prior to discharge. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Occupational Therapy**	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for initial evaluations, or for services provided within 30 days following discharge from hospital when ordered by physician prior to discharge. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for initial evaluations, or for services provided within 30 days following discharge from hospital when ordered by physician prior to discharge. See Covered Services and Limitations Rule 405 IAC 5.	
Respiratory Therapy*	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for inpatient or outpatient hospital, emergency, oxygen in nursing facility, 30 days following discharge from hospital when ordered by physician prior to discharge.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year per type of therapy.	Must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization not required for inpatient or outpatient hospital, emergency, oxygen in nursing facility, 30 days following discharge from hospital when ordered by physician prior to discharge.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Prescribed (Legend) Drugs	See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	See Covered Services and Limitations Rule 405 IAC 5.	See Covered Services and Limitations Rule 405 IAC 5.	
Over-the-counter (Non-legend) Drugs	See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Not covered except for insulin.	See Covered Services and Limitations Rule 405 IAC 5.	
Inpatient Rehabilitative Services**	See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covered up to 50 days per calendar year.	See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Intermediate Care Facilities for the Mentally Retarded**	Preadmission diagnosis and evaluation required. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.		Preadmission diagnosis and evaluation required. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services.	
Community Mental Health Rehabilitation	Includes outpatient mental health services, partial hospitalization (group activity program) and case management. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.		Includes outpatient mental health services, partial hospitalization (group activity program) and case management. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Outpatient mental health/substance abuse services	Includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Office visits limited to a maximum of four per month or 20 per year per member without prior approval. See Covered Services and Limitations Rule 405 IAC 5.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covers outpatient mental health/substance abuse services when the services are medically necessary for the diagnosis or treatment of the member's condition except when provided in an institution for mental diseases with more than 16 beds. Office visits limited to a maximum of 30 per year per member without prior approval to a maximum of 50 visits per year.	Includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology. Office visits limited to a maximum of four per month or 20 per year per member without prior approval. See Covered Services and Limitations Rule 405 IAC 5.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Inpatient mental health/substance abuse services**	Each member admitted must have an individually developed plan of care developed by the physician and interdisciplinary team. Plan of care must be reviewed and updated every thirty days by the interdisciplinary team. Recertification is required every 60 days.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Inpatient mental health/substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member's condition except when they are provided in an institution for mental diseases with more than 16 beds.	Each member admitted must have an individually developed plan of care developed by the physician and interdisciplinary team. Plan of care must be reviewed and updated every thirty days by the interdisciplinary team. Recertification is required every 60 days.	
Hospice care**	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.	Must be expected to die from illness within six months. Coverage of two consecutive periods of 90 days followed by an unlimited number of periods of 60 days.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Case Management for Persons with HIV**	Targeted case management services limited to no more than 60 hours per quarter.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.		Targeted case management services limited to no more than 60 hours per quarter.	
Case Management for Pregnant Women**	Limited to one initial assessment, one reassessment per trimester, and one postpartum assessment.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.		Limited to one initial assessment, one reassessment per trimester, and one postpartum assessment.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Case Management for Mentally Ill or Emotionally Disturbed	Targeted case management services limited to those provided by or under supervision of qualified mental health professionals who are employees of a provider agency approved by the Department of Mental Health.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.		Targeted case management services limited to those provided by or under supervision of qualified mental health professionals who are employees of a provider agency approved by the Department of Mental Health.	
Non-emergency Transportation	Non-emergency travel available for up to 20 one-way trips of less than 50 miles per year without prior authorization.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician.	Non-emergency travel available for up to 20 one-way trips of less than 50 miles per year without prior authorization.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Emergency Transportation*	No limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covers emergency ambulance transportation using the prudent layperson standard as defined in state insurance law I.C. 27-13-1-11.7.	No limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge.	
Diabetes Self Management Training Services*	Limited to 16 units per member per year. Additional units may be prior authorized.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Limited to 16 units per member per year. Additional units may be prior authorized.	Limited to 16 units per member per year. Additional units may be prior authorized.	
Organ Transplants	Covered in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.		Covered in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Out-of-state Medical Services**	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Prior authorization is not required for emergency services provided out of state, but once the member is stable prior authorization must be obtained.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Coverage is subject to any limitations included in the CHIP benefit package.	Covers acute general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Prior authorization is not required for emergency services provided out of state, but once the member is stable prior authorization must be obtained.	
Orthodontics	Covered when medically necessary.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covered when medically necessary.	Covered when medically necessary.	

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Service	Package A - Standard Plan	Package B - Pregnancy Coverage Only	Package C - Children's Health Plan	Package D - Hoosier Healthwise for Persons With Disabilities and Chronic Illnesses	Package E - Emergency Services Only
Food Supplements, Nutritional Supplements, and Infant Formulas**	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions which may complicate the pregnancy or urgent care services.	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	

***Prior approval always required*

**Prior approval required under certain circumstances*

Shaded areas represent no coverage