

## **APPENDIX 6.1**

### **HUSKY B Plan Benefit Package**

#### **COVERED BENEFITS (\*)**

- Prior authorization may be required by the MCO or Department unless otherwise noted by an asterisk (\*).
- Copayment not required for preventive services.

<b>Benefit Features</b>	<b>HUSKY Coverage</b>																											
<b>Outpatient Physician Visits</b>	\$10copay																											
<b>Preventive Care</b>	<p>No copay                      Periodic and well child visits, immunizations, WIC evaluations as applicable, and prenatal care covered in full with \$10 copay on other visits.  <b>Periodicity schedule</b> and reporting based on the American Academy of Pediatrics (AAP) as amended from time to time:</p> <table border="0"> <thead> <tr> <th><b>Age Category</b></th> <th><b># of Exams</b></th> </tr> </thead> <tbody> <tr> <td>Birth to Age 1</td> <td>6 exams</td> </tr> <tr> <td>Ages 1-5</td> <td>6 exams</td> </tr> <tr> <td>Ages 6-10</td> <td>1 exam every 2 yrs.</td> </tr> <tr> <td>Ages 11-19</td> <td>1 exam every yr.</td> </tr> </tbody> </table> <p><b>Immunization schedule</b> per the Advisory Committee on Immunization Practices (ACIP), as amended from time to time. As of January 1, 2001, the schedule is as follows:</p> <table border="0"> <thead> <tr> <th><b>Age Category</b></th> <th><b>Vaccine Type</b></th> </tr> </thead> <tbody> <tr> <td>Birth</td> <td>Hepatitis B-1<sup>st</sup> dose</td> </tr> <tr> <td>1-4 mos.</td> <td>Hepatitis B-2<sup>nd</sup> dose</td> </tr> <tr> <td>2 mos.</td> <td>Diphtheria, Tetanus, Pertussis (DTP)-1<sup>st</sup> Dose; Haemophilus Influenza Type B (hib)-1<sup>st</sup> dose; Polio (OVP)-1<sup>st</sup> dose</td> </tr> <tr> <td>4 mos.</td> <td>Diphtheria, Tetanus, Pertussis (DTP)-2<sup>nd</sup> Dose; Haemophilus Influenza Type B (hib)-2<sup>nd</sup> dose; Polio (OVP)-2<sup>nd</sup> dose</td> </tr> <tr> <td>6 mos.</td> <td>Diphtheria, Tetanus, Pertussis (DTP)-3<sup>rd</sup> Dose; Haemophilus Influenza Type B (hib)-3<sup>rd</sup> dose</td> </tr> <tr> <td>6-12 mos.</td> <td>Hepatitis B-3<sup>rd</sup> dose; Polio (OVP)-3<sup>rd</sup> Dose</td> </tr> <tr> <td>12-15 mos.</td> <td>Haemophilus</td> </tr> </tbody> </table>	<b>Age Category</b>	<b># of Exams</b>	Birth to Age 1	6 exams	Ages 1-5	6 exams	Ages 6-10	1 exam every 2 yrs.	Ages 11-19	1 exam every yr.	<b>Age Category</b>	<b>Vaccine Type</b>	Birth	Hepatitis B-1 <sup>st</sup> dose	1-4 mos.	Hepatitis B-2 <sup>nd</sup> dose	2 mos.	Diphtheria, Tetanus, Pertussis (DTP)-1 <sup>st</sup> Dose; Haemophilus Influenza Type B (hib)-1 <sup>st</sup> dose; Polio (OVP)-1 <sup>st</sup> dose	4 mos.	Diphtheria, Tetanus, Pertussis (DTP)-2 <sup>nd</sup> Dose; Haemophilus Influenza Type B (hib)-2 <sup>nd</sup> dose; Polio (OVP)-2 <sup>nd</sup> dose	6 mos.	Diphtheria, Tetanus, Pertussis (DTP)-3 <sup>rd</sup> Dose; Haemophilus Influenza Type B (hib)-3 <sup>rd</sup> dose	6-12 mos.	Hepatitis B-3 <sup>rd</sup> dose; Polio (OVP)-3 <sup>rd</sup> Dose	12-15 mos.	Haemophilus	*
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	<p>12-18 mos.</p> <p>4-6 yrs.</p> <p>11-12 yrs.</p>	<p>Influenza (hib)-3<sup>rd</sup> Dose; Measles, Mumps, Rubella (MMR)-1<sup>st</sup> dose                  Chicken Pox (Var)-single dose;                  Diphtheria, Tetanus, Pertussis (DTP)-4<sup>th</sup> Dose                  Diphtheria, Tetanus, Pertussis (DTP)-5<sup>th</sup> Dose; Measles, Mumps, Rubella (MMR)-2<sup>nd</sup> dose;                  Polio (OVP)-4<sup>th</sup> Dose                  Tetanus Diphtheria (Td)</p> <p><u>Influenza</u>—Every year beginning at 6 months for children who have serious long-term health problems such as heart disease, lung disease, kidney disease, metabolic disease, diabetes, asthma, anemia, &amp;/or are on long-term aspirin treatment.</p> <p><u>Pneumococcal</u>—Vaccinate children 2 years and older who are at risk of pneumococcal disease or its complications.</p>	
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<b>Family Planning</b> Family Planning services include: Reproductive health exams; Patient counseling; Patient education; Lab tests to detect the presence of conditions affecting reproductive health; Screening, testing and treatment; Pre and post-test counseling for sexually transmitted diseases and HIV; abortions that are necessary to save the life of the mother or if the pregnancy resulted from rape or incest; and other medically necessary abortions as defined in Section 3.14 of the contract, until the MCO and Department execute a separate abortion contract.	100%	
Preventive Family Planning Services	100%	*
Oral Contraceptives	\$5 copay if generic or \$10 copay if brand name (included in prescription drugs)	*
<b>Inpatient Physician</b>	100%	
<b>Inpatient Hospital</b>	100%	
<b>Outpatient Surgical Facility</b>	100%	
<b>Ambulance</b>	100% if determined to be an emergency in accordance with state law	
<b>Pre-Admission/Continued Stay</b>	Arranged through provider	
<b>Prescription Drug</b>	\$5 copay on generics \$10 copay on brand name	
<b>Mental Health</b> Inpatient	100%	
Outpatient	\$10 copay	
<b>Substance Abuse</b> Detoxification Inpatient	100%	
Outpatient	\$10 copay	
<b>Short Term Rehabilitation for conditions where significant improvement is expected</b>	100%	

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<b>within sixty days, including: Physical Therapy, Speech Therapy, Occupational Therapy and Skilled Nursing Care (excludes private duty nursing), behavioral health home-based and emergency mobile rehab.</b>		
<b>Home Health Care (includes disposable medical supplies) for homebound members</b>	100%, excludes custodial care; homemaker care or care that may be provided in a medical office, hospital or skilled nursing facility and offered to member in such setting.	
<b>Hospice</b>	100%, provided to members who are diagnosed as having a terminal illness with a life expectancy of six months or less. Covered care includes nursing care, physical therapy, speech therapy, and occupational therapy; medical social services; home health aides and homemakers; medical supplies; drugs; appliances; DME; physician services; short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management; services of volunteers and other benefits when ordered by a physician. Limitations on short-term therapies do not apply.	
<b>Long Term Rehabilitation, Long Term Physical Therapy and Long Term Skilled Nursing Care. Includes behavioral health home-based and emergency mobile rehab.</b>	Not covered under HUSKY B.  Supplemental coverage available under HUSKY Plus behavioral and HUSKY Plus physical for children with special medical or behavioral needs.	

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<b>Lab and X-Ray</b>	100%	
<b>Pre-Admission Testing</b>	100%	
<b>Emergency Care</b>	100% if determined to be an emergency in accordance with state law.	*
<p><b>Durable Medical Equipment (DME) means equipment, furnished by a supplier or home health agency that: (1) can withstand repeated use; (2) is primarily and customarily used to serve a medical purpose; (3) is generally not useful to an individual in the absence of an illness or injury; and (4) is appropriate for use in the home.</b></p> <p><b>Hearing Aids</b></p>	<p>100%</p> <p>Does not include power wheelchairs for members eligible for HUSKY Plus Physical; devices not medical in nature, such as, whirlpools, saunas, elevators, vans, van lifts, home convenience items (e.g., air cleaners, filtration units and related apparatus, exercise bicycles and other types of exercise equipment), insulin injectors, non-rigid appliances and supplies, such as, sheets, self-help devices, experimental or investigational research equipment, and items for personal comfort and or usefulness to the members' household.</p> <p>Hearing aids for children twelve years of age or younger, limited to \$1,000.00 within a 24-month period.</p> <p>Supplemental coverage available under HUSKY Plus for medically eligible children.</p>	

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<b>Prosthetics –Devices whether worn anatomically or surgically implanted, which replace all or part of a body organ or structure and which correct, strengthen or provide necessary support to the body, will be covered when medically necessary.</b>	100% Does not include orthopedic shoes, foot orthotics, wigs or hairpieces. Supplemental coverage available under HUSKY Plus for medically eligible children.	
<b>Eye Care</b> Eye Exams	\$15 copay	
<b>Hearing Exam</b>	\$15 copay	
<b>Nurse Midwives</b>	\$10copay (except for preventive services)	
<b>Nurse Practitioners</b>	\$10 copay (except for preventive services)	
<b>Podiatrists</b>	\$10 copay	
<b>Chiropractors</b>	\$10 copay	
<b>Naturopaths</b>	\$10 copay	
<b>Dental</b> Dental services include: Exams, 1 every 6 months; X-Rays; Fluoride Treatments	100%	*
<b><u>LIMITED BENEFITS</u></b>		
<b><u>Benefit Features</u></b>	<b><u>HUSKY Coverage</u></b>	
<b>Eye Care</b> Eyeglass frames and lenses or contact lenses	Once every 2 consecutive eligibility periods with an allowance of \$100 toward the purchase of these goods. The optical hardware must be provided without charge under the following conditions: (i) one pair of contact lenses every 2 consecutive eligibility periods when such lenses are determined to be the primary and the best method for aiding the member vision and the lenses are not needed solely for the correction of vision; (ii) eyeglass frames and lenses and contact lenses that are	

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	(iii) determined to be medically necessary after eye surgery, the initial pair only; and contact lenses, as needed, for the treatment of Keratonconus.	
<b>Dental</b>		
Orthodontia	\$725 allowance per orthodontia case.	
Re-cement bridges, crowns, inlays & spacemaintainers	20% co-insurance	
Repair, Relining & Rebasing dentures	20% co-insurance	
Root canal treatment/endodontic surgery	20% co-insurance	
Miscellaneous procedures and miscellaneous surgical procedures	20% co-insurance	
Simple extraction	20% co-insurance	
Amalgam and composite restorations (fillings)	20% co-insurance	
General anesthesia	20% co-insurance	
Full & Partial Denture	50% co-insurance	
Periodontal Surgery	50% co-insurance	
Surgical extraction, including wisdom tooth	33% co-insurance	
Space maintainers	33% co-insurance	
Crowns, Inlays and Onlays/Prosthodontics	33% co-insurance	
<b>Contraceptives</b>		
Intrauterine Device (IUD) and insertion of the IUD	\$10 copay for office visit if non-preventive 100% for device	
Internally implantable time-release devices & their insertion	\$10 copay for office visit if non-preventive 100% for device	
Time re-released contraceptive injections	\$10 copay for office visit if non-preventive 100% for injection	
<b>Nutritional Formulas</b>	100% limited to medically necessary amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases when ordered by a participating physician	

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## EXCLUSIONS AND LIMITATIONS

1. Services and/or procedures considered to be of an unproven, experimental, or research nature or cosmetic, social, habilitative, vocational, recreational, or educational.
2. Services in excess of those deemed medically necessary to treat the patient's condition.
3. Services for a condition that is not medical in nature.
4. Devices required by third parties, such as school or employment physicals, physicals for summer camp, enrollment in health, athletic, or similar clubs, premarital blood work or physicals, or physicals required by insurance companies or court ordered alcohol or drug abuse course.
5. Cosmetic and reconstructive surgery is excluded, except when surgery is required for:
  - a) reconstructive surgery in connection with the treatment of malignant tumors or other destructive pathology that causes dysfunction;
  - b) reduction mammoplasty in females when Medically Necessary and breast surgery in males only in cases of suspected malignancy. Surgery must be necessary to achieve normal physical or bodily function.
6. Routine foot care rendered:
  - a) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the foot;
  - b) in the cutting, trimming or other non-operative partial removal of toenails, except when Medically Necessary in the treatment of neuro-circulatory conditions.
7. Evaluation, treatment and procedures related to, and performance of, sex-change operations.
8. Surgical treatment or hospitalization for the treatment of morbid obesity except where prior authorized as Medically Necessary.
9. Care, treatment, procedures, services or supplies that are primarily for dietary control including, but not limited to, any exercise or weight reduction programs, whether formal or informal, and whether or not recommended by an In-network Physician or an Out-of-Network Physician.
10. Acupuncture biofeedback, or hypnosis.
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11. Treatment at pain clinics unless determined to be Medically Necessary.

12. Ambulatory blood pressure monitoring.

13. Any court order for testing, diagnosis, care, or treatment deemed not Medically Necessary.

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