BadgerCare Plus and Wisconsin Medicaid Covered Services Comparison Chart

The covered services information in the following chart is provided as general information. Providers should refer to their service-specific publications and the ForwardHealth Online Handbook for detailed information on covered and noncovered services and prior authorization (PA) information.

Service	Coverage Under the BadgerCare Plus Standard Plan and Wisconsin Medicaid	Coverage Under the BadgerCare Plus Benchmark Plan	Coverage Under the BadgerCare Plus Core Plan	Coverage Under the BadgerCare Plus Basic Plan
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. $3.00 copayment per service.	Coverage of certain surgical procedures and related lab services. $15.00 copayment per visit.	Coverage of certain surgical procedures and related lab services. $3.00 copayment per service.	Coverage of certain surgical and related procedures. Limited to five visits per enrollment year. $60.00 copayment per visit.
Chiropractic	Full coverage. $0.50 to $3.00 copayment per service.	Full coverage. $15.00 copayment per visit.	Full coverage. $0.50 to $3.00 copayment per service.	Full coverage. Initial visits and chiropractic manipulative treatments are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists.

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Chiropractic (Continued)				$10.00 copayment per visit.
Dental	Full coverage. $0.50 to $3.00 copayment per service.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and surgical procedures for pregnant women and children. Coverage limited to $750.00 per enrollment year. A $200.00 deductible applies to all services except preventive and diagnostic. Cost-sharing equal to 50 percent of allowable fee on all services. Pregnant women are exempt from deductible and cost-sharing requirements for dental services.	Coverage limited to certain emergency services. No copayment.	Coverage limited to certain emergency services. $10.00 copayment per visit.
Disposable Medical Supplies (DMS)	Full coverage. $0.50 to $3.00 copayment per service and $0.50 per prescription for diabetic supplies.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME). $0.50 copayment per	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME. $0.50 to $3.00 copayment per service.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME. Up to $5.00 copayment per priced unit for most DMS.

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DMS (Continued)		prescription for diabetic supplies. No copayment for other DMS.	$0.50 per prescription for diabetic supplies.	$0.50 per prescription for diabetic supplies. Prescriptions for diabetic supplies do not count towards the member's limit of 10 prescriptions per calendar month.
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to 5 prescriptions per month for opioid drugs. Copayments are as follows: • $0.50 for OTC drugs. • $1.00 for generic drugs. • $3.00 for brand name drugs. Copayments are limited to $12.00 per member, per provider, per month. Over-the-counter drugs are excluded from this $12.00 maximum.	Generic-only formulary drug benefit and some OTC drugs. Member are limited to 5 prescriptions per month for opioid drugs Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. $5.00 copayment with no upper limits.	Generic-only formulary drug and some OTC drugs. Some brand name drugs are covered. Members are limited to 5 prescriptions per month for opioid drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. Up to $4.00 copayment for generic drugs and up to $8.00 for brand name drugs with a $24.00 copayment limit per month, per provider.	Generic-only formulary drug benefit and some OTC drugs. Humalog, Humalog Mix, Lantus, Tamiflu, and Relenza are the only brand name drugs covered. Prescriptions are limited to a total of 10 per calendar month. Of the 10 total prescriptions allowed per month, up to 5 prescriptions per month are covered for opioid drugs. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions.

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Drugs (Continued)				There is up to a $5.00 copayment per generic drug prescription with no upper limit. There is a $10.00 copayment for brand name drugs. There is a $10.00 copayment for the flu shot.
Durable Medical Equipment (DME)	Full coverage. $0.50 to $3.00 copayment per item. Rental items are not subject to copayment.	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 enrollment year limit. The following items do not count towards the $2,500.00 enrollment year limit: • Hearing aids, hearing aid batteries, and accessories. • Bone-anchored hearing aids. • Cochlear implants. Hearing aid repairs are subject to the $2,500.00 enrollment year limit.	Full coverage up to $2,500.00 per enrollment year. $0.50 to $3.00 copayment per item. Rental items are not subject to copayment but count toward the $2,500.00 annual limit.	Full coverage up to $500.00 per enrollment year. Up to $10.00 copayment per item. Copayment for blood glucose meters is $0.50 per prescription. Rental items are not subject to copayment but count toward the $500.00 annual limit.
End-Stage Renal Disease (ESRD)	Full coverage. No copayment.	Full coverage. No copayment.	Full coverage. No copayment.	Full coverage. End-stage renal disease providers who bill ESRD

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ESRD (Continued)				services as an ESRD facility are not subject to the outpatient hospital limits. $10.00 copayment per visit.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. $1.00 copayment per screening for members 18, 19, and 20 years of age.	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. $1.00 copayment per screening for members 18, 19, and 20 years of age.	Not applicable.	Not applicable.
Hearing Services	Full coverage. $0.50 to $3.00 copayment per procedure. No copayment for hearing aid batteries.	Full coverage for members 17 years of age and younger. $15.00 per visit, regardless of the number or type of procedures administered during one visit.	No coverage.	No coverage.

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Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	Full coverage of PDN, home health, and personal care services. No copayment.	Full coverage of home health services. Coverage limited to 60 visits per enrollment year. Private duty nursing and personal care services are not covered. $15.00 copayment per visit.	Coverage of home health services for 30 days following an inpatient stay if discharge from the hospital is contingent on the provision of follow-up home health services. Coverage is limited to 100 visits within the 30-day post-hospitalization period. No copayment.	No coverage.
Hospice	Full coverage. No copayment.	Full coverage, up to 360 days per lifetime. No copayment.	Full coverage. No copayment.	Full coverage. No copayment.
Inpatient Hospital	Full coverage. $3.00 copayment per day with a $75.00 cap per stay.	Full coverage. Copayments are as follows: • $100.00 stay for medical stays. • $50.00 copayment per stay for mental health and/or substance abuse treatment.	Full coverage (not including inpatient psychiatric stays in either an Institute for Mental Disease [IMD] or the psychiatric ward of an acute care hospital and inpatient substance abuse treatment). $3.00 copayment per day for members with income up to 100 percent of the Federal Poverty Level (FPL) with a $75.00 cap per stay.	Full coverage for the first inpatient stay with authorization (not including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital or inpatient stays for transplant services). If the first stay is a transfer, both providers are required to have authorization. Subsequent inpatient stays are

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Inpatient Hospital (Continued)			$100.00 copayment per stay for members with income from 100 percent to 200 percent of the FPL. There is a $300.00 total copayment cap per enrollment year for inpatient and outpatient hospital services for all income levels.	subject to the $7,500.00 deductible per enrollment year for inpatient and outpatient hospital services (excluding emergency room). Reimbursement for per diem facility stays will be capped at the length of 14 days. Outlier costs and hospital access payments are not included in the reimbursement rate. There is a $100.00 copayment per covered stay for nondeductible inpatient hospital stays.
Mental Health and Substance Abuse Treatment	Full coverage (not including room and board). $0.50 to $3.00 copayment per service, limited to the first 15 hours or $825.00 of services, whichever comes first, provided per calendar year. Copayment not required when	Coverage of this service is based on the Wisconsin State Employee Health Plan. Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), adult mental health day treatment for adults, substance abuse day	Coverage limited to services provided by a psychiatrist under the physician services benefit. $0.50 to $3.00 copayment per service, limited $30.00 per provider, per enrollment year.	Coverage limited to services provided by a psychiatrist under the physician services benefit. Certain covered services by psychiatrists are counted toward the combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers:

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Mental Health and Substance Abuse Treatment (Continued)	services are provided in a hospital setting.	treatment for adults and children, child/adolescent mental health day treatment, and inpatient hospital stays for mental health and substance abuse. Services not covered are crisis intervention, community support program, comprehensive community services, outpatient mental health services in the home and community for adults, community recovery services, and substance abuse residential treatment. *Note*: No copayments may be charged for child/adolescent day treatment services provided to BadgerCare Plus Benchmark Plan members. Child/adolescent day treatment services are HealthCheck "Other Services." $10.00 to $15.00 copayment per visit for all outpatient hospital services: • $10.00 per day for all day treatment services.		• Chiropractors. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists.

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Mental Health and Substance Abuse Treatment (Continued)		• $15.00 per visit for narcotic treatment services (no copayment for lab tests). • $15.00 per visit for outpatient mental health diagnostic interview exam, psychotherapy — individual or group (no copayment for electroconvulsive therapy and pharmacological management). • $15.00 per visit for outpatient substance abuse services.		
Nursing Home Services	Full coverage. No copayment.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year. No copayment.	No coverage.	No coverage.
Outpatient Hospital — Emergency Room	Full coverage. No copayment.	Full coverage. $60.00 copayment per visit (waived if the member is admitted to a hospital).	Full coverage. $3.00 copayment for members with income up to 100 percent of the FPL. $60.00 copayment per visit for members with income from 100 percent to 200 percent of the FPL (waived if the member is admitted to a hospital).	Full coverage, limited to two visits per enrollment year. $60.00 copayment per visit (waived if the member is admitted to a hospital).

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Outpatient Hospital	Full coverage. $3.00 copayment per visit.	Full coverage. $15.00 copayment per visit.	Full coverage. Outpatient mental health and substance abuse treatment services are not covered. $3.00 copayment per visit for members with income up to 100 percent of the FPL. $15.00 copayment per visit for members with income from 100 percent to 200 percent of the FPL. $300.00 total copayment cap per enrollment year for inpatient and outpatient hospital services for all income levels.	Full coverage for the first five outpatient non-emergency room visits with authorization. Subsequent visits covered after the first five outpatient visits are subject to the $7,500.00 deductible per enrollment year for inpatient and outpatient hospital services (excluding emergency room). After the deductible is reached, full coverage of outpatient hospital services. Payment will not include outliers. There is a $60.00 copayment per visit for nondeductible visits.

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Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology (SLP)	Full coverage. $0.50 to $3.00 copayment per service. Copayment obligation limited to the first 30 hours or $1,500.00, whichever occurs first, during one calendar year (copayment limits calculated separately for each discipline).	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. Also covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. (The cardiac rehabilitation visits do not count towards the 20-visit limit for PT.) Also covers up to a maximum of 60 SLP therapy visits over 20-week period following a bone anchored hearing aid or cochlear implant surgeries for members 17 years of age and younger. These SLP services do not count towards the 20-visit limit for SLP. $15.00 copayment per visit, per provider. There are no monthly or annual copayment limits.	Full coverage, limited to 20 visits per therapy discipline, per enrollment year. (Cardiac rehabilitation visits count towards the 20-visit limit for PT.) $0.50 to $3.00 copayment per service. Copayment obligation limited to the first 30 hours or $1,500.00, whichever occurs first, during one enrollment year (copayment limits calculated separately for each discipline).	Full coverage, limited to 10 visits per therapy discipline, per enrollment year. (Cardiac rehabilitation visits count towards the 10-visit limit for PT.) $10.00 copayment per visit.
Physician	Full coverage, including laboratory and radiology. $0.50 to $3.00 copayment per	Full coverage, including laboratory and radiology. $15.00 copayment per visit.	Full coverage, including laboratory and radiology. $0.50 to $3.00 copayment per	Full coverage, including laboratory and radiology, although certain visits are subject to a combined 10-visit

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Physician (Continued)	service, limited to $30.00 per provider per calendar year. No copayment for emergency services, anesthesia, or clozapine management.	No copayment for emergency services, anesthesia, or clozapine management.	service, limited to $30.00 per provider per enrollment year. No copayment for emergency services, anesthesia, or clozapine management.	limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. Transplants and transplant-related services are not covered. Provider-administered drugs are not covered. There is a $10.00 copayment per visit. Most radiology services have a $5.00 or $20.00 copayment.
Podiatry	Full coverage. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per calendar year.	Full coverage. $15.00 copayment per visit.	Full coverage. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per enrollment year.	Full coverage, although certain visits are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors.

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Podiatry (Continued)				• Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. There is a $10.00 copayment per visit.
Prenatal/Maternity Care	Full coverage, including Prenatal Care Coordination (PNCC), and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.	Full coverage, including PNCC, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.	Not applicable.	Not applicable.
Reproductive Health Service	Full coverage, excluding infertility treatments, surrogate parenting and related services, including but not limited to artificial insemination and subsequent obstetrical care as a non covered service, and the reversal of voluntary sterilization.	Full coverage, excluding infertility treatments, surrogate parenting and related services, including but not limited to artificial insemination and subsequent obstetrical care as a non covered service, and the reversal of voluntary sterilization.	Family planning services provided by family planning clinics will be covered separately under the Family Planning Only Services (FPOS).	Family planning services provided by family planning clinics will be covered separately under the FPOS.

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Reproductive Health Service (Continued)	No copayment for family planning services.	No copayment for family planning services.		
Routine Vision	Full coverage including coverage of eyeglasses. $0.50 to $3.00 copayment per service.	One eye exam per enrollment year, with refraction. $15.00 copayment per visit.	General ophthalmological services are covered if billed with *CPT* codes 92002-92014 and certain qualifying diagnosis codes.	General ophthalmological services are covered if billed with *CPT* codes 92002-92014 and certain qualifying diagnosis codes. Certain visits are subject to a combined 10-visit limit. The combined 10-visit limit applies to certain visits provided by the following providers: • Chiropractors. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists.

Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $2.00 copayment for non-emergency ambulance trips. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier or emergency ambulance.	Full coverage of emergency and non-emergency transportation to and from a certified provider for a covered service. Copayments are as follows: • $50.00 copayment per trip for emergency transportation by ambulance. • $1.00 copayment per trip for transportation by SMV. • No copayment for transportation by common carrier.	Coverage limited to emergency transportation by ambulance. No copayment.	Coverage limited to emergency transportation by ambulance. No copayment.

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