

BadgerCare Plus Standard Plan Covered Services Overview

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
Ambulatory Surgery Centers	Coverage of certain surgical procedures and related lab services. \$3.00 copayment per service.
Chiropractic	Full coverage. \$0.50 to \$3.00 copayment per service.
Dental	Full coverage. \$0.50 to \$3.00 copayment per service.
Disposable Medical Supplies	Full coverage. \$0.50 to \$3.00 copayment per service and \$0.50 per prescription for diabetic supplies.
Drugs	Comprehensive drug benefit with coverage of generic and brand name prescription drugs and some over-the-counter (OTC) drugs. Members are limited to five prescriptions per month for opioid drugs. Copayments are as follows: <ul style="list-style-type: none"> • \$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.
Durable Medical Equipment	Full coverage. \$0.50 to \$3.00 copayment per item. Rental items are not subject to copayment.
End-Stage Renal Disease	Full coverage. No copayment.
Health Screenings for Children	Full coverage of HealthCheck screenings and other services for individuals under the age of 21. No copayment.

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Hearing Services	<p>Full coverage.</p> <p>\$0.50 to \$3.00 copayment per procedure.</p> <p>No copayment for hearing aid batteries.</p>
Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)	<p>Full coverage of PDN, home health, and personal care services.</p> <p>No copayment.</p>
Hospice	<p>Full coverage.</p> <p>No copayment.</p>
Inpatient Hospital	<p>Full coverage.</p> <p>\$3.00 copayment per day with a \$75.00 cap per stay.</p>
Mental Health and Substance Abuse Treatment	<p>Full coverage (not including room and board).</p> <p>\$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.</p> <p>Copayment not required when services are provided in a hospital setting.</p>
Nursing Home Services	<p>Full coverage.</p> <p>No copayment.</p>
Outpatient Hospital — Emergency Room	<p>Full coverage.</p> <p>No copayment.</p>
Outpatient Hospital	<p>Full coverage.</p> <p>\$3.00 copayment per visit.</p>
Physical Therapy, Occupational Therapy, and Speech and Language Pathology	<p>Full coverage.</p> <p>\$0.50 to \$3.00 copayment per service.</p> <p>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).</p>
Physician	<p>Full coverage, including laboratory and radiology.</p> <p>\$0.50 to \$3.00 copayment per service, limited to \$30.00 per provider per calendar year.</p> <p>No copayment for preventive services, emergency services, anesthesia, or clozapine management.</p>

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Podiatry	Full coverage. \$0.50 to \$3.00 copayment per service, limited to \$30.00 per provider per calendar year.
Prenatal/Maternity Care	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems. No copayment.
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 noncovered service, and the reversal of voluntary sterilization. No copayment for family planning services.
Routine Vision	Full coverage including coverage of eyeglasses. \$0.50 to \$3.00 copayment per service.
Transportation — Ambulance, Specialized Medical Vehicle (SMV), Common Carrier	Full coverage of emergency and non-emergency medical transportation to and from a certified provider for a covered service. Copayments are as follows: <ul style="list-style-type: none"> • \$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.

Note: For additional information on copayments, providers may refer to the Copayment chapter of the Reimbursement section of their specific-service area of the Online Handbook at www.forwardhealth.wi.gov/.