ForwardHealth
Wisconsin serving you

Update
June 2010

No. 2010-42

Affected Programs: BadgerCare Plus, Medicaid
To: All Providers, HMOs and Other Managed Care Programs

Introducing the BadgerCare Plus Basic Plan

The Department of Health Services will begin accepting applications for enrollment in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010.

This *ForwardHealth Update* provides general information about the program. Future *Updates* will provide service-specific program information.

A separate *Update* (2010-41), titled "BadgerCare Basic Plan Training Available for Providers," was issued regarding provider training for the Basic Plan.

Overview of BadgerCare Plus Basic Plan Implementation

In October 2009, enrollment in the BadgerCare Plus Core Plan was closed. Enrollment applications submitted to the Core Plan after the cutoff date are not processed, but the individuals are put on a waitlist.

Individuals on the waitlist for the Core Plan can begin enrolling in the BadgerCare Plus Basic Plan on June 1, 2010, with benefits starting on July 1, 2010. The Basic Plan is a self-funded plan that focuses on providing Core Plan waitlist members with access to vital, cost-effective primary and preventive care. This option will allow members to have some minimal form of coverage until space becomes available in the Core Plan and will help prevent bankruptcy due to excessive medical debt.

Member participation or non-participation in the Basic Plan does not affect an individual's status on the Core Plan waitlist.

Services for the Basic Plan will be covered under fee-for-service. Basic Plan members will not be enrolled in state-contracted HMOs.

Application Process for New Members

Applicant Enrollment Requirements

Applicants are required to apply for the Core Plan and be put on the waitlist before they can enroll in the Basic Plan. To enroll in the Core Plan and thus qualify for the Core Plan waitlist and the Basic Plan, the applicant must meet the following program requirements:

- Be a Wisconsin resident.
- Be a United States citizen or legal immigrant.
- Be between the ages of 19 and 64.
- Not have any children under age 19 under his or her care.
- Not be pregnant.
- Not be eligible for or enrolled in Medicaid, the BadgerCare Plus Standard Plan, or the BadgerCare Plus Benchmark Plan. Applicants may be enrolled in the Family Planning Waiver (FPW) or Tuberculosis-Related Services Only.
- Not be eligible for or enrolled in Medicare.
- Have a monthly gross income that does not exceed 200 percent of the Federal Poverty Level.
- Not be covered by health insurance currently or in the previous 12 months unless there is justifiable cause.
- Not have had access to employer-sponsored insurance in the previous 12 months and does not

have access to employer-subsidized insurance during the month of application or any of the three months following application.

Application Process for New Members

Individuals who wish to enroll in the Basic Plan must first apply for the Core Plan online at *access.wi.gov/* or via a toll-free telephone number. A pre-screening tool at *access.wi.gov/* will help determine which individuals may be eligible to enroll in the Core Plan. Applications for Core Plan members are processed by the Enrollment Services Center, not by county agencies.

Once the Core Plan application process is complete and the individual has been placed on the waitlist for the Core Plan, the individual will have the option to enroll in the Basic Plan. An informational letter will be mailed to individuals on the waitlist with Basic Plan information and a coupon the individual can use to request enrollment in the Basic Plan and submit his or her initial premium payment. Members of the Basic Plan will be required to pay a monthly premium of approximately $130.00 to maintain coverage. Members who fail to pay the monthly premium will have their Basic Plan coverage terminated and will be subject to a restrictive re-enrollment period, which will not allow the member to re-enroll for 12 months. Termination of Basic Plan coverage does not affect a member's status on the Core Plan waitlist or his or her eligibility for the Core Plan if room becomes available.

Conditions That End Member Enrollment in the Basic Plan

A member's enrollment in the Basic Plan will end if the member:

- Becomes eligible for Medicare, Medicaid, the Standard Plan, the Benchmark Plan, or the Core Plan.
- Becomes incarcerated or becomes institutionalized in an Institution for Mental Disease (IMD).
- Becomes pregnant. (*Note:* A Basic Plan member who becomes pregnant should be referred to Member Services at (800) 362-3002 for more information about enrollment in the Standard Plan or the Benchmark Plan.)
- No longer resides in the state of Wisconsin.
- Obtains health insurance coverage.
- Turns 65 years of age.
- Fails to pay the monthly premium.

Note: Enrollment in the Basic Plan does not end if the member's income increases.

Providers are reminded that the Basic Plan does not cover obstetrical services or delivery services.

Providers are required to notify ForwardHealth if they have reason to believe that a person is misusing or abusing BadgerCare Plus or Medicaid benefits or the ForwardHealth identification card. Refer to the Online Handbook for more information.

Basic Plan Member Fact Sheets

Fact sheets providing additional member information about the Basic Plan are available at *dhs.wisconsin.gov/badgercareplus/core/index.htm*.

Enrollment Certification Period for Basic Plan Members

A member's enrollment will begin on the first of the month and will continue through the end of the 12th month. For example, if the individual's enrollment in the Basic Plan begins on July 1, 2010, the enrollment certification period will continue through June 30, 2011, unless conditions occur that end enrollment.

Premium payments are due on the fifth of each month, prior to the month of coverage. Members who fail to pay the monthly premium will have their benefits terminated and will also be subject to a 12-month restrictive re-enrollment period.

Enrollment Year Under the Basic Plan

Definition of an Enrollment Year Under the Basic Plan

The Basic Plan enrollment year is the time period used to determine service limitations for members in the Basic Plan.

The Basic Plan enrollment year is defined as the continuous 12-month period beginning on the first day of enrollment (the first day of the month) in the Basic Plan and ending on the last day of the 12th full calendar month.

When a member exceeds his or her service limitations, the service is considered noncovered and the member is responsible for payment of the service.

New ForwardHealth Basic Plan Identification Cards

Members enrolled in the Basic Plan will receive a ForwardHealth Basic Plan card. All identification cards include the member's name and 10-digit member identification number. The identification cards may be used to verify a member's enrollment, but possession of an identification card does not guarantee enrollment. It is possible that a member will present a card when he or she is not enrolled; therefore, it is essential that providers verify enrollment before providing services.

Providers should always check enrollment for a member who presents a ForwardHealth card to verify if the member is enrolled in the Basic Plan or in one of the other ForwardHealth programs. (Providers may use the same methods of enrollment verification under the Basic Plan as they do for other ForwardHealth programs such as Medicaid. These methods include the ForwardHealth Portal, WiCall, magnetic stripe card readers, and the 270/271 Health Care Eligibility/Benefit Inquiry and Information Response transactions.) Members who present a ForwardHealth card or a ForwardHealth Basic Plan card may have been enrolled in a different plan since the card was issued. Providers should be careful to verify the plan in which the member is enrolled and know which services are covered under that plan.

Basic Plan members should call Member Services at (800) 362-3002 with questions about premiums and covered services. The ForwardHealth Basic Plan card includes the Member Services telephone number on the back. Refer to Attachment 1 of this *Update* for a sample ForwardHealth Basic Plan card.

Overview of Covered and Noncovered Services

Covered services under the Basic Plan include the following:

- Ambulatory surgery center services limited to five visits per enrollment year.
- Chiropractic services subject to a combined 10-visit limit per enrollment year. The combined 10-visit limit applies to certain visits provided by podiatrists, physicians (including psychiatrists and ophthalmologists), physician assistants, nurse practitioners, optometrists, and chiropractors.
- Physician services, including primary and preventive care and diagnostic, surgical, and medicine services. Certain physician visits are subject to a combined 10-visit limit per enrollment year. The combined 10-visit limit applies to certain visits provided by podiatrists, physicians (including psychiatrists and ophthalmologists), physician assistants, nurse practitioners, optometrists, and chiropractors.
- Diagnostic services, including laboratory and radiology.
- End-Stage Renal Disease services.
- Hospice services.
- Inpatient hospital stays limited to the first inpatient stay with authorization per enrollment year. Subsequent inpatient stays are subject to the $7,500.00 deductible per enrollment year for inpatient and outpatient hospital services. Inpatient hospital stays for psychiatric services in either an

IMD or the psychiatric ward of an acute care hospital or for transplant services are not covered.

- Outpatient hospital visits limited to five visits with authorization per enrollment year. 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.
- Emergency ambulance services.
- Certain emergency dental services.
- Emergency outpatient hospital services, limited to five visits per enrollment year.
- Certain generic drugs, some over-the-counter drugs, and a limited number of brand name drugs. Total prescriptions are limited to 10 prescriptions per calendar month. Drugs that are not covered by the Basic Plan may be available through BadgerRx Gold.
- Physical therapy (PT), occupational therapy, and speech and language pathology services limited to 10 visits per discipline, per member, per enrollment year. Cardiac rehabilitation visits are covered under PT and are subject to PT service limitations.
- Durable medical equipment (DME) limited to $500.00 per enrollment year.
- Disposable medical supplies (DMS), including certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME.
- Podiatry services. Certain podiatry visits are subject to a combined 10-visit limit per enrollment year. The combined 10-visit limit applies to certain visits provided by podiatrists, physicians (including psychiatrists and ophthalmologists), physician assistants, nurse practitioners, optometrists, and chiropractors.

Services provided by optometrists and ophthalmologists are covered by the Basic Plan *except* for routine vision services. For example, refraction is not covered by the Basic Plan, but eye infections and eye injuries would be covered. For specific information on visits that count toward the combined 10-visit limit described under the physician services bullet in this section, refer to the June 2010 *ForwardHealth Update* (2010-43), titled "Coverage of Certain Medical Services Under the BadgerCare Plus Basic Plan."

Family planning services provided by a family planning clinic may be covered by the FPW for members who are enrolled in that program.

Transplants and transplant-related services are *not* covered by the Basic Plan.

Inpatient mental health services and substance abuse treatment are *not* covered by the Basic Plan. Outpatient mental health and outpatient substance abuse treatment services are generally *not* covered by the Basic Plan. However, some services provided by psychiatrists are covered. Certain covered services provided by psychiatrists are counted toward the combined 10-visit limit described under the physician services bullet in this section.

Services that exceed the dollar amount limit or service limit are considered non-covered services and members are responsible for payment for noncovered services.

Providers should refer to service-specific *Updates* for detailed information on covered and noncovered services.

Service-specific *Updates* with detailed information about covered and noncovered services under the Basic Plan may be accessed on the ForwardHealth Portal at *www.forwardhealth.gov/* by selecting the link titled "BadgerCare Plus Basic Plan Information" under "Hot Topics" on the Portal home page. Attachment 2 lists the service-specific Basic Plan *Updates*.

Refer to Attachments 3 and 4 for general information about covered and noncovered services and service limitations. For a table comparing coverage for the Basic Plan with the Standard Plan, the Benchmark Plan, and the Core Plan, refer to Attachment 5.

Billing Members for Noncovered Services

Basic Plan members may request noncovered services from providers. In those cases, providers may collect payment for the noncovered service from the member if the member accepts responsibility for payment and makes payment arrangements with the provider. Providers are strongly encouraged to obtain a written statement in advance documenting that the member has accepted responsibility for payment of the service.

Providers may bill members up to their usual and customary charge for noncovered services. Basic Plan members do not have appeal rights for noncovered services.

Copayments

Providers should consult their service-specific publications for more information about services that require copayments; some services do not have copayments under the Basic Plan.

Under the Basic Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Attachment 3 includes some copayment information.

Reimbursement

Generally, providers will be reimbursed for services provided to members enrolled in the Basic Plan at the current Wisconsin Medicaid rate of reimbursement for covered services.

Providers should refer to service-specific publications for specific reimbursement information.

Basic Plan Members Enrolled in Wisconsin Chronic Disease Program

For Basic Plan members who are also enrolled in Wisconsin Chronic Disease Program (WCDP), providers should submit claims for all covered services to the Basic Plan first and then to WCDP. For pharmacy services, if both programs deny the pharmacy claim, providers should submit the claim to BadgerRx Gold.

Basic Plan Members and HIRSP Coverage

Basic Plan members may also be enrolled in the Health Insurance Risk Sharing Plan (HIRSP) as long as the member meets the eligibility requirements for both the Basic Plan and HIRSP. For Basic Plan members who are also enrolled in HIRSP, providers should submit claims for all Basic Plan covered services to HIRSP first and then to the Basic Plan.

Basic Plan members may not be enrolled in the Basic Plan and the Federal Temporary High Risk Insurance Pool. Refer to Attachment 6 for information that is being distributed to Core Plan members on the waitlist regarding HIRSP and the Federal Temporary High Risk Insurance Pool.

Enrollment Verification

The Basic Plan offers different covered services, noncovered services, and copayments than the Standard Plan, the Benchmark Plan, or the Core Plan. It is imperative that providers verify a member's enrollment and determine the plan under which he or she is covered. Providers are reminded to *always* verify a member's enrollment *before* providing services to determine enrollment at the current date (since a member's enrollment status may change) and discover any limitations to the member's coverage.

Training

Providers may refer to *Update* (2010-41), titled "BadgerCare Basic Plan Training Available for Providers," for information about Basic Plan training sessions.

For More Information

For more information or questions regarding the Basic Plan, providers may call Provider Services at (800) 947-9627. Basic Plan members should contact Member Services at (800) 362-3002.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

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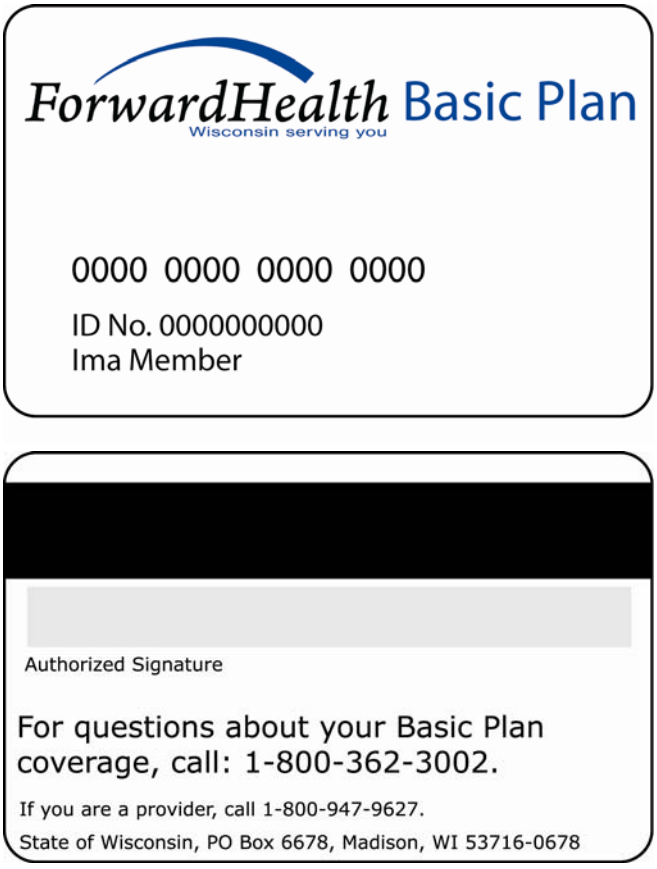
ATTACHMENT 1
ForwardHealth Basic Plan Card



ATTACHMENT 2
BadgerCare Plus Basic Plan Publications

The following table lists the *ForwardHealth Updates* describing the BadgerCare Plus Basic Plan and service-specific coverage, policies, and procedures under the Basic Plan. Providers should refer to the Basic Plan link under "Hot Topics" on the ForwardHealth Portal home page at *www.forwardhealth.wi.gov/* for the service-specific *Updates*.

***Update* Title**	***Update* Number**
Introducing the BadgerCare Plus Basic Plan	2010-42
Coverage of Certain Medical Services Under the BadgerCare Plus Basic Plan	2010-43
Ambulance Services Covered Under the BadgerCare Plus Basic Plan	2010-44
Ambulatory Surgery Center Services Covered Under the BadgerCare Plus Basic Plan	2010-45
Dental Services Covered Under the BadgerCare Plus Basic Plan	2010-46
Disposable Medical Supplies Covered Under the BadgerCare Plus Basic Plan	2010-47
Durable Medical Equipment Covered Under the BadgerCare Plus Basic Plan	2010-48
End-Stage Renal Disease Services Covered Under the BadgerCare Plus Basic Plan	2010-49
Hospice Services Covered Under the BadgerCare Plus Basic Plan	2010-50
Hospital Services Covered Under the BadgerCare Plus Basic Plan	2010-51
Pharmacy Services Covered Under the BadgerCare Plus Basic Plan	2010-52
Physical Therapy, Occupational Therapy, and Speech and Language Pathology Services Covered Under the BadgerCare Plus Basic Plan	2010-53

ATTACHMENT 3
At-a-Glance Summary of BadgerCare Plus Basic Plan Covered Services

The covered services information in the following chart is provided as general information. Providers should refer to their service-specific publications and the Online Handbook for detailed information on covered and noncovered services, copayment amounts and limits, and prior authorization information.

Service	Coverage Under the BadgerCare Plus Basic Plan
Ambulatory Surgery Centers	Coverage of certain surgical and related procedures. Limited to five visits per enrollment year. There is a $60.00 copayment per visit.
Chiropractic	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. There is a $10.00 copayment per visit.
Dental	Coverage limited to certain emergency services. There is a $10.00 copayment per visit.
Disposable Medical Supplies (DMS)	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME). There is up to a $5.00 copayment per priced unit for most DMS. There is a $0.50 copayment per prescription for diabetic supplies.

Service	Coverage Under the BadgerCare Plus Basic Plan
Drugs	Certain generic drugs and a limited number of over-the-counter (OTC) drugs. Humalog, Humalog Mix, Lantus, Tamiflu, and Relenza are the only brand name drugs covered. Prescriptions are limited to 10 per calendar month. There is up to a $5.00 copayment per prescription with no upper limit. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions.
DME	Full coverage up to $500.00 per enrollment year. There is up to a $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	Full coverage. End-stage renal disease (ESRD) providers who bill ESRD services as an ESRD facility are not subject to the outpatient hospital limits. There is a $10.00 copayment per visit.
Hospice	Full coverage. There is no copayment.
Inpatient Hospital	Full coverage for the first inpatient stay with authorization (not including inpatient psychiatric stays in either an Institute of Mental Disease 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 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.

Service	Coverage Under the BadgerCare Plus Basic Plan
Outpatient Hospital — Emergency Room	Full coverage, limited to five visits per enrollment year. There is a $60.00 copayment per visit, which is waived if the member is admitted to the hospital.
Outpatient Hospital	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.
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology	Full coverage, limited to 10 visits per therapy discipline, per enrollment year. (Cardiac rehabilitation visits count towards the 10-visit limit for PT.) There is a $10.00 copayment per visit.
Physician	Full coverage, including laboratory and radiology, 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. • 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.
Podiatry	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. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. There is a $10.00 copayment per visit.

Service	Coverage Under the BadgerCare Plus Basic Plan
Reproductive Health Services	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver.
Smoking Cessation Drugs	Coverage includes prescription generic and OTC tobacco cessation products. Refer to the drug benefit for information on copayments.
Transportation — Ambulance, Specialized Medical Vehicle, Common Carrier	Coverage limited to emergency transportation by ambulance. There is no copayment.

ATTACHMENT 4
Services Not Covered Under the BadgerCare Plus Basic Plan

The following are among the services that are not covered under the BadgerCare Plus Basic Plan:

- Case management.
- Certain visits over the 10-visit limit.
- Enteral nutrition.
- HealthCheck services.
- Health education services.
- Hearing services, including hearing instruments, cochlear implants and bone-anchored hearing devices, hearing aid batteries, and repairs.
- Home care services (home health, personal care, private duty nursing).
- Inpatient mental health and substance abuse treatment services.
- Non-emergency transportation (i.e., common carrier, specialized medical vehicle).
- Nursing home.
- Obstetrical care and delivery.
- Outpatient mental health and substance abuse services.
- Prenatal care coordination.
- Provider-administered drugs.
- Routine vision.
- School-Based Services.
- Transplants and transplant-related services.

ATTACHMENT 5
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).

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
Chiropractic (Continued)				• Physician assistants. • Podiatrists. $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	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME).	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME.	Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of DME.

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
DMS (Continued)	supplies.	$0.50 copayment per prescription for diabetic supplies. No copayment for other DMS.	$0.50 to $3.00 copayment per service and $0.50 per prescription for diabetic supplies.	Up to $5.00 copayment per priced unit for most DMS 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. 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 with a few generic OTC 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 benefit with a limited number of OTC drugs. Some brand name drugs are covered. 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.	Certain generic drugs and a limited number of OTC drugs. Humalog, Humalog Mix, Lantus, Tamiflu, and Relenza are the only brand name drugs covered. Prescriptions are limited to 10 per calendar month. There is up to a $5.00 copayment per prescription with no upper limit. Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions.
DME	Full coverage. $0.50 to $3.00 copayment per item.	Full coverage up to $2,500.00 per enrollment year. $5.00 copayment per item.	Full coverage up to $2,500.00 per enrollment year. $0.50 to $3.00 copayment per	Full coverage up to $500.00 per enrollment year. Up to $10.00 copayment per

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
DME (Continued)	Rental items are not subject to copayment.	Rental items are not subject to copayment but count toward the $2,500.00 annual limit.	item. Rental items are not subject to copayment but count toward the $2,500.00 annual limit.	item. Copayment for blood glucose meters $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 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 HealthCheck Outreach and Case Management. HealthCheck "Other Services" and Interperiodic services for individuals under the age of 21 are not covered. No copayment.	Not applicable.	Not applicable.

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
Hearing Services	Full coverage. $0.50 to $3.00 copayment per procedure. No copayment for hearing aid batteries.	Limited coverage of services provided by an audiologist. Hearing aids, hearing aid batteries, cochlear implants, and bone-anchored hearing devices are not covered. $15.00 per visit, regardless of the number or type of procedures administered during one visit.	No coverage.	No coverage.
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.

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
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. $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.	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 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.

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
Inpatient Hospital (Continued)				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 services provided in a hospital setting.	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 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, and substance abuse residential treatment.	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: • Chiropractors. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists.

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
Mental Health and Substance Abuse Treatment (Continued)		$10.00 to $15.00 copayment per visit for all outpatient hospital services: • $10.00 per day for all day treatment services. • $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. No copayment for members with income up to 100 percent of the FPL.	Full coverage, limited to five visits per enrollment year. $60.00 copayment per visit (waived if the member is

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
Outpatient Hospital — Emergency Room (Continued)			$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).	admitted to a hospital).
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.

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
Physical Therapy (PT), Occupational Therapy, and Speech and Language Pathology	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.) $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 service, limited to $30.00 per provider per calendar year. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. $15.00 copayment per visit. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology. $0.50 to $3.00 copayment per service, limited to $30.00 per provider per enrollment year. No copayment for emergency services, anesthesia, or clozapine management.	Full coverage, including laboratory and radiology, 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. • Nurse practitioners. • Optometrists. • Physicians (including

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
Physician (Continued)				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.
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. • Nurse practitioners. • Optometrists. • Physicians (including psychiatrists and ophthalmologists). • Physician assistants. • Podiatrists. There is a $10.00 copayment per visit.

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
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 the reversal of voluntary sterilization. No copayment for family planning services.	Full coverage, excluding infertility treatments, surrogate parenting, and the reversal of voluntary sterilization. No copayment for family planning services.	Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver (FPW).	Family planning services provided by family planning clinics will be covered separately under the FPW.
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.	No coverage.	No coverage.
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.	Coverage limited to emergency transportation by ambulance. $50.00 copayment per trip.	Coverage limited to emergency transportation by ambulance. No copayment.	Coverage limited to emergency transportation by ambulance. No copayment.

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
Transportation — Ambulance, SMV, Common Carrier (Continued)	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.			

Note: The covered services information in this chart is provided as general information. Providers should refer to their service-specific publications and the Online Handbook for detailed information on covered and noncovered services and PA information.

ATTACHMENT 6
Alternatives to the BadgerCare Plus Basic Plan

Before enrolling in the BadgerCare Plus Basic Plan, you should consider two other insurance options available to some Wisconsin residents. Enrolling in BadgerCare Plus Basic will make you ineligible for coverage under the Federal Pool option described below.

Option 1: Health Insurance Risk-Sharing Plan (HIRSP)

You may qualify for HIRSP if:

1. You recently lost your employer-sponsored insurance coverage; or
2. You have been rejected for coverage in the private insurance market; or
3. You have HIV/AIDS; or
4. You have Medicare because of a disability.

HIRSP offers comprehensive medical and pharmacy benefits including coverage of brand name drugs and $150 of first dollar coverage on routine/preventive services. HIRSP will not cover medical services for a preexisting condition for the first six months of coverage. The preexisting condition waiting period does not apply to drug coverage. The medical services preexisting condition waiting period does not apply if you qualify for HIRSP because you have recently lost your employer-sponsored coverage.

If your annual household income is below $33,000, you may be entitled to a premium and deductible subsidy. For example, a 25 year old man with an annual income of less than $10,000 would pay $89 per month for a $2,500 deductible insurance plan.

HIRSP members can also be enrolled in the BadgerCare Plus Basic or Core Plan.

Option 2: Federal Temporary High Risk Insurance Pool

You may qualify for the new Federal Pool if:

1. You are a citizen or national of the United States, or are lawfully present;
2. You have a preexisting medical condition; and
3. You have been uninsured for at least 6 months before applying for coverage.

The Federal Pool will offer the same medical and drug benefits as HIRSP. There is no preexisting condition waiting period under the Federal Pool.

In most cases, the Federal Pool premium will be lower than the HIRSP premium.
Enrollment is expected to begin in July 2010, for coverage beginning August 1, 2010.

If you enroll in BadgerCare Plus Basic or HIRSP now, you will not be eligible for the Federal Pool. You should determine which program best serves your needs. For more information about HIRSP or the Federal Pool and your insurance options, please contact HIRSP Customer Service at 1.800.828.4777 or visit *www.hirsp.org*