

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
ADAP (Aids Drug Assistance Program)		x											Y	This plan covers specific prescriptions only.	
ADSS (Aged/Disabled SSI Related)	x	x	x	x	x	x						x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	No waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.
ALEN (Emergency Services for Aliens)			x	x	x								Y	This plan only covers emergency services treated by medical providers. Emergency services are limited to situations where going without medical treatment could cause serious danger, loss of a bodily function, or severe pain (including labor and delivery).	This plan does not cover dental, vision, prescriptions, waiver or nursing home services and does not pay co-insurance and deductibles on Medicare claims.
BCC (Breast and Cervical Cancer)				x	x								N	This plan covers outpatient hospital and medical services for providers who are enrolled with the Breast and Cervical Cancer Program. In addition, coverage is limited to specific screening services. For more information contact the BCC Program at 800-264-1296.	
CMHW (Children's Mental Health Wavier)	x	x	x	x	x	x	x		x	x	x		Y	This plan covers dental, prescriptions, inpatient hospital stays, outpatient hospital, medical, vision and waiver services, pays co-insurance and deductibles on Medicare claims.	This plan does not cover nursing home services.

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
CSH1 (Children's Special Health - Special Needs Children)		x	x	x	x	x						x	Y	This plan covers services for specific diagnoses or conditions as approved by the CSH Program. For additional information contact CSH at 1-800-438-5795.	
CSH2 (Children's Special Health - Moms and Babies)		x	x	x	x	x						x	Y	This plan covers services for specific diagnoses or conditions as approved by the CSH Program. For additional information contact CSH at 1-800-438-5795.	
DDAW (DD Adult Wavier)	x	x	x	x	x	x	x					x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	No nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.
DDCW (DD Children's Wavier)	x	x	x	x	x	x	x					x	Y	This plan covers dental, prescriptions, inpatient hospital stays, outpatient hospital, medical, vision and waiver services, and pays co-insurance and deductibles on Medicare claims.	This plan does not cover nursing home services.
FPW (Pregnant By Choice)		x	x	x	x								Y	This plan only covers prescriptions, inpatient hospital stays, outpatient hospital and medical services related to family planning methods and products approved by the FDA.	This plan does not cover abortion, infertility services and/or treatments, or sterilization reversals.

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
MDP (Marginal Dental Program)	x												Y	This plan receives Dental coverage only, with a maximum of 1,000 dollars total payment limitation per year and receives 85% of billed charges, the client is responsible for remaining 15%. Eligibility is determined annually. For additional information contact the Marginal Dental Program at (307)777-7945.	
EID (Employed Individual Disabled)	x	x	x	x	x	x						x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	No waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.
HSPC (Hospice Only)	x	x	x	x	x	x	x					x	Y	This plan covers services provided by physicians and the attending hospice provider. Prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, co-insurance and deductibles on Medicare claims and limited dental and vision services are covered when not related to the client's terminal illness and approved by the hospice provider.	No nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
IP65 (Inpatient Psychology Services)	x	x	x	x	x	x		x				x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and nursing home services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	No waiver services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.
KIDA (Standard Full Coverage Child Medicaid)	x	x	x	x	x	x						x	Y	This plan covers dental, prescriptions, inpatient hospital stays, outpatient hospital, medical, and vision services, and pays co-insurance and deductibles on Medicare claims.	This plan does not cover waiver or nursing home services.
KIDB (Kid Care CHIPs - Handled by BCBS since 10/1/03)	x	x	x	x	x	x						x	Y	No current coverage - plan taken over by BCBS on 10/1/03.	
LTCS (Long Term Care Screening)					x								N	This plan covers LT101 and PASRR screenings only.	
MATR (Maternity)	x	x	x	x	x	x						x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	This plan does not cover waiver or nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
MCAD (Standard Full Coverage Adult Medicaid)	x	x	x	x	x	x						x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	This plan does not cover waiver or nursing home services. Dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.
MDCS (Maternal Dental Care Services - Ended 4/2004)	x												Y	No current coverage - plan ended 4/2004	
PDAP (Prescription Drug Assistance Program - Listed as MMP in the MMIS)		x			x								Y	This plan covers 3 prescriptions per month and oxygen services not covered by Medicare only.	
MMRX (Renal Program)		x											Y	This plan covers specific renal prescriptions only.	
MQIB (Medicare Qualified Individual - B Premium)													N	This plan pays Medicare Part B premiums only.	
MQIP (Medicare Qualified Individual - B Premium and Prescriptions)		x											Y	This plan covers 3 prescriptions per month, pays Medicare Part B premiums and oxygen services not covered by Medicare only.	

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
NH (Nursing Home)	x	x	x	x	x	x		x				x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and nursing home services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	No waiver services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.
NOHN (No Nursing Home or Wavier)	x	x	x	x	x	x						x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	No waiver or nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.
PE (Presumptive Eligibility)		x		x	x	x						x	Y	This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited vision services.	This plan does not cover inpatient hospital stays, waiver, nursing home or dental services. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.
POUT (Project Out)					x								N	This plan is limited to providers who are enrolled with the Project Out Program and coverage is limited specific medical services. For more information contact the Project Out Program at 800-442-2766.	

EqualityCare and State Health Care Plans

Plan Name	Coverage Types												Card?	Covered Services	Limitations
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
QMB (Qualified Medicare Beneficiary)											x	x	Y	This plan pays Medicare Part B premiums and co-insurance and deductibles on Medicare claims only.	
QMBP (Qualified Medicare Beneficiary with Prescriptions)		x									x	x	Y	This plan covers 3 prescriptions per month, pays co-insurance and deductibles on Medicare claims, pays Medicare Part B premiums and oxygen services not covered by Medicare.	
QWDI (Qualified Working Disabled Individual)									x				N	This plan pays Medicare Part A premiums only.	
SCM (Targeted Case Management)					x								N	This plan covers screening services for the Developmentally Disabled Waiver Program only.	
SHPS (State Licensed Shelter Care)								x				x	Y	This plan covers nursing home services only and pays co-insurance and deductibles on Medicare claims.	
SLMB (Special Low-Income Medicare Beneficiaries)											x		N	This plan pays Medicare Part B premiums only.	
SLMP (Special Low-Income Medicare Beneficiaries with Prescriptions)		x									x		Y	This plan covers 3 prescriptions per month, pays Medicare Part B premiums and oxygen services not covered by Medicare only	

EqualityCare and State Health Care Plans

Plan Name	Coverage Types											Card?	Covered Services	Limitations	
	D	Rx	I	O	M	V	W	N	AP	BP	C/D				
TBI (Tuberculosis Infected)	x	x		x	x	x						x	Y	This plan covers prescriptions, outpatient hospital and medical services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	This plan does not cover inpatient hospital stays, waiver or nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan.
WLTC (Wavier Long Term Care)	x	x	x	x	x	x	x					x	Y	This plan covers prescriptions, inpatient hospital stays, outpatient hospital, medical and waiver services, pays co-insurance and deductibles on Medicare claims and limited dental and vision services.	This plan does not cover nursing home services. Adult (21 yrs of age and older) dental coverage is limited to one preventative visit per year (including basic cleaning and x-rays) and covers basic fillings, emergency services, endodontics (root canals) and full and partial dentures. Adult (21 yrs of age and older) vision services are limited to medical eye examinations related to eye disease or injury. Glasses and contacts are not covered under this plan for adults.

Key					
D	Dental	V	Vision	C/D	Medicare Co-Insurance
Rx	Prescriptions	W	Wavier		
I	Inpatient	N	Nursing Home		
O	Outpatient	AP	Part A Premiums		
M	Medical / CMS - 1500	BP	Part B Premiums		