

MILWAUKEE GAMP/ BC+ CORE PLAN FOR CHILDLESS ADULTS – BENEFITS COMPARISON

SERVICE	GAMP	BADGERCARE PLUS CORE PLAN FOR CHILDLESS ADULTS
DRUGS		
Benefit	Generic and name-brand drugs; limited to GAMP formulary.	Generic-only formulary drug benefit with a few generic OTC drugs. Members will be automatically enrolled in the Badger Rx Gold plan. This is a separate program administered by Navitus, which provides for a discount on the cost of brand name drugs.
Limits	If a generic is available, the patient must use the generic. \$900/month limit on drug coverage. \$400/month limit on narcotics.	Brand name diabetes, asthma and mental health drugs are only covered for individuals previously covered under the General Assistance Medical Program.
Co-Pay	\$3 generic, \$5 name brand.	\$5 co-payment with a \$20 limit per month, per provider.
DENTAL		
Benefit	Extractions only, “evaluation of tooth pain” can be covered.	Coverage limited to emergency services only.
Limits	See above.	See above.
Co-pay	None.	None.
THERAPY (Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)		
Benefits	Medically necessary therapies are covered.	Full coverage.
Limits	Limit of 40 visits/year. In-home PT available if condition prevents patient from going to a facility. In-home OT & speech are not available. Prior authorization required.	Limited to 20 visits per therapy discipline per enrollment year.
Co-pay	None.	\$0.50 to \$3 co-payment per service. Co-payment obligation limited to the first 30 hours or \$1,500, whichever occurs first, during one calendar year (co-payment limits calculated separately for each discipline).

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PODIATRIC SERVICES		
Benefits	Covered for diabetics & individuals with peripheral vascular conditions.	Not covered.
Limits	See above.	N/A
Co-pay	None.	N/A
VISION		
Benefits	Diabetes or medically-related vision services are covered. Glaucoma screens for high risk patients are covered.	No coverage.
Limits	See above.	N/A
Co-pay	None.	N/A
OUTPATIENT HOSPITAL		
Benefits	Covered per Medicaid rules for outpatient coverage.	Full coverage including emergency room.
Limits	Dialysis is not covered. ER covered only if life or limb threatening or authorized by the primary clinic or the nurse call line.	None.
Co-pay	\$20 co-pay for ER only.	<p>\$3 co-payment per visit for members with income up to 100% FPL; \$15 co-payment per visit for members with income from 100% to 200% FPL.</p> <p>\$300 total co-payment cap per year for inpatient and outpatient hospital services for all income levels.</p> <p>Emergency room: No co-payment for members with income up to 100% FPL.</p> <p>\$60 co-payment per visit for members with income from 100% to 200% FPL (waived if member admitted to hospital).</p>

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<i>HOME CARE SERVICES</i>		
Benefits	Medically necessary, intermittent skilled care provided by a RN or Physical Therapist.	No coverage.
Limits	Covered only when it is provided in lieu of hospitalization.	N/A
Co-pay	None.	N/A
<i>DISPOSABLE MEDICAL SUPPLIES</i>		
Benefits	Covered.	Coverage of syringes, diabetic pens and DMS that is required with the use of a DME item.
Limits	Some items require prior authorization.	See above.
Co-pay	None.	\$0.50 co-payment per item.
<i>DURABLE MEDICAL EQUIPMENT</i>		
Benefits	Medically necessary DME is covered. Home oxygen covered w/ some restrictions. Prior authorization is required.	Full coverage.
Limits	Does not cover items available through retail (such as crutches, canes, walkers).	Up to \$2,500 per enrollment year.
Co-pay	None.	\$0.50 to \$3 co-payment per item. Rental items are not subject to co-payment but count toward the \$2,500 annual limit.
<i>INPATIENT HOSPITAL</i>		
Benefits	Full coverage at contracted hospitals.	Full coverage.
Limits	Psych, hospice, sub-acute and non-acute rehabilitation not covered.	Not including inpatient psychiatric or substance abuse stays in either an IMD or the psychiatric ward of an acute care hospital.

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Co-pay	None.	<p>\$3 co-payment per day for members with income up to 100% FPL with a \$75 cap per stay.</p> <p>\$100 co-payment per stay for members with income from 100% to 200% FPL.</p> <p>There is a \$300 total co-payment cap per year for inpatient and outpatient hospital services for all income levels.</p>
PHYSICIAN VISITS		
Benefits	Full coverage (office visits and surgical procedures), including lab and radiology.	Full coverage (office visits and surgical procedures), including lab and radiology.
Limits	Must be at the participant’s chosen Primary Care Provider (PCP) or other provider if resulting from PCP referral.	None.
Co-pay	None.	<p>\$0.50 to \$3 co-payment per service, limited to \$30 per provider per calendar year.</p> <p>No co-payment for emergency services, preventive care, anesthesia or clozapine management.</p>
SMOKING CESSATION SERVICES		
Benefits	Not covered.	Coverage includes prescription generic and over the counter tobacco cessation products.
Limits	N/A	See above.
Co-pay	N/A	Refer to the drug benefit for information on co-payments.

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<i>REPRODUCTIVE HEALTH SERVICES</i>			
Benefits	Not covered.		Family planning services provided by family planning clinics will be covered separately under the Family Planning Waiver program.
Limits	N/A		N/A
Co-pay	N/A		N/A
<i>MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT</i>			
Benefits	Not covered.		Coverage limited to mental health therapy services provided by a psychiatrist only.
Limits	N/A		See above.
Co-pay	N/A		\$0.50 to \$3 co-payment per service, limited to \$30 per provider, per calendar year.
<i>TRANSPORTATION</i>			
Benefits	Ambulance covered in emergency to any hospital in Milwaukee County.		Coverage limited to emergency transportation by ambulance.
Limits	Emergency only, does not cover transportation to medical appointments.		See above.
Co-pay	None		None
<i>LAB TESTS AND XRAY</i>			
Benefits	Diagnostic X-rays and lab tests are covered.		Full coverage.
Limits			As part of physician's services.
Co-pay	None.		\$0.50 to \$3 co-payment per physician's service, limited to \$30 per provider per calendar year.

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SERVICE	GAMP	BADGERCARE PLUS CORE PLAN FOR CHILDLESS ADULTS
<i>CHIROPRACTIC SERVICES</i>		
Benefits	Covered.	Covered.
Limits		
Co-pay	\$0.50 to \$3 co-payment per service.	\$0.50 to \$3 co-payment per service.
<i>HOSPICE</i>		
Benefits	Not covered.	Not covered.
Limits	Not covered.	Not covered.
Co-pay	Not covered.	Not covered.
<i>NURSING HOME</i>		
Benefits	Not covered.	Not covered.
Limits	Not covered.	Not covered.
Co-pay	Not covered.	Not covered.



State of Wisconsin
Department of Health Services

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