Hoosier Healthwise Program Comparison

The following table compares benefit packages of the Hoosier Healthwise Programs. The following bullet items apply throughout Table 2-4:

- Medicaid covered services and limitations in Packages A and B are cited in Title 405, Article 5 of the Indiana Administrative Code. Package C covered services and limitations are cited in Title 407, Article 3 of the Indiana Administrative Code. Indiana Administrative Code can be found on the State's website: www.state.in.us/legislative/iac.

- Reimbursed under RBMC: Services not reimbursed under RBMC are covered (available) and reimbursed for the RBMC members under traditional Medicaid benefits reimbursement unless otherwise indicated in the Package A, B, and C notes.

- Service - In PCCM and Traditional FFS Medicaid benefits and services: *Prior Approval Required Under Certain Circumstances and **Prior Approval Always Required

- Service - In RBMC: In general, all non-contracted out-of-network providers require prior approval. For contracted, in-network providers please contact MCO for more information about whether prior authorizations from the plan are required.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits

Benefit	Reimbursed Under RBMC	Package A Standard Plan	Package B Pregnancy Coverage Only	Package C Children's Health Plan
Case Management for Persons with HIV/AIDS	YES (Self-referral)	Targeted case management services limited to no more than 60 hours per quarter.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered service
Case Management for Mentally Ill or Emotionally Disturbed	NO	Targeted case management services limited to those provided by or under supervision of qualified mental health professionals who are employees of a provider agency approved by the Department of Mental Health.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered service
Case Management for Pregnant Women** (405 IAC 5-11)	YES	Limited to one initial assessment, one reassessment per trimester, and one postpartum assessment.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered service

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Chiropractors* (405 IAC 5-12)	YES (Self-referral)	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member per year.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 14 therapeutic physical medicine treatments per member per calendar year. An additional 36 treatments may be covered if prior approval is obtained based on medical necessity. There is a 50-treatment limit per calendar year.
Chronic Disease Management	YES (Asthma)	Coverage available to qualified recipients with chronic diseases such as congestive heart failure, diabetes, asthma, HIV/AIDS to enhance, support or train on self-management skills.	Coverage available to qualified recipients with chronic diseases such as congestive heart failure, diabetes, asthma, HIV/AIDS to enhance, support or train on self-management skills.	Coverage available to qualified recipients with chronic diseases such as congestive heart failure, diabetes, asthma, HIV/AIDS to enhance, support or train on self-management skills.
Dental Services (405 IAC 5-14)	NO	In accordance with Federal law, all medically necessary dental services are provided for children under age 21 even if the service is not otherwise covered under Package A. Benefit limit $600.00 per year for ages 21 years and older.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	All medically necessary dental services are provided for children enrolled in Package C even if the service is not otherwise covered under CHIP.
Diabetes Self Management Training Services* (405-IAC 5-36)	YES	Limited to 16 units per member per year. Additional units may be prior authorized.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Limited to 16 units per member per year. Additional units may be prior authorized.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Drugs - Prescribed (Legend) Drugs (405 IAC 5-24)	YES	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Medicaid covers legend drugs if the drug is: approved by the United States Food and Drug Administration; not designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid
Drugs -Over-the-counter (Non-legend)	YES	Medicaid covers non-legend (over-the-counter) drugs on its formulary. This is available at: http://www.indianapbm.com	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Not covered except for insulin.
Early Intervention Services (Early Prevention and Screening, Diagnosis and Treatment [EPSDT])	YES	Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary health care services in accordance with the HealthWatch EPSDT periodicity and screening schedule.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covers immunizations, and initial and periodic screenings according to the HealthWatch EPSDT periodicity and screening schedule. Coverage of treatment services is subject to the Package C benefit package coverage limitations.
Emergency and Post-Stabilization Services (IC 12-15-12-15 & -17)	YES (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Eye Care, Eyeglasses and Vision Services (405 IAC 5-23)	YES (Self-referral)	Coverage for the initial vision care examination will be limited to one examination per year for a member under 19 years of age and one examination every two years for a recipient 19 years of age or older unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age and one pair every two years for members 19 years and older.	Non-covered.	Vision care examination is limited to one examination per year for a member under 19 years of age unless more frequent care is medically necessary. Coverage for eyeglasses, including frames and lenses, will be limited to a maximum of one pair per year for members under 19 years of age except when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen, or broken beyond repair.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Family Planning Services and Supplies (IHCP Provider Manual, Chapter 8 and Prime*Step* Manual)	YES (Self-referral)	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision-making process for choice of contraception; initial diagnosis and treatment (no on-going treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Family planning services include: limited history and physical examination; pregnancy testing and counseling; provision of contraceptive pills, devices, and supplies; education and counseling on contraceptive methods; laboratory tests, if medically indicated as part of the decision- making process for choice of contraception; initial diagnosis and treatment (no on-going treatment) of sexually transmitted diseases (STDs); screening, and counseling of members at risk for HIV and referral and treatment; tubal ligation; vasectomies. Pap smears are included as a family planning service if performed according to the United States Preventative Services Task Force Guidelines.
Federally Qualified Health Centers (FQHCs)	YES	Coverage is available for medically necessary services provided by licensed health care practitioners.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for medically necessary services provided by licensed health care practitioners.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	YES	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covered only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.
Hospital Services - Inpatient* (405-IAC 5-16)	YES	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services - Outpatient*	YES	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Outpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home Health Services** (405 IAC 5-16)	YES	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available to home health agencies for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.
Hospice care** (405 IAC 5-34)	NO	Non-covered for PCCM and RBMC members. Member must be disenrolled from Hoosier Healthwise before benefit can begin. Hospice is available under Medicaid if the recipient is expected to die from illness within six months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days.		

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Laboratory and Radiology Services (405 IAC 5-18)	YES	Services must be ordered by a physician.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), and conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a physician.
Medical supplies and equipment (includes prosthetic devices, implants, hearing aids, dentures, etc.)** (405 IAC 5-19)	YES (Except dentures or dental devices, dental products and dental supplies)	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covered when medically necessary. Maximum benefit of $2,000 per year or $5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased depending on which is more cost-efficient.
Mental health/ substance abuse services-Inpatient (State Psychiatric Hospital or Free-standing Psychiatric Facility)** (405 IAC 5-20-1)	NO, unless services rendered in acute care hospital.	Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between 22 and 65 years of age in a certified psychiatric hospital of 16 beds or less.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Inpatient mental health/substance abuse services are covered when the services are medically necessary for the diagnosis or treatment of the member's condition except when they are provided in an institution for treatment of mental diseases with more than 16 beds.
Mental health/ substance abuse services-Outpatient	NO	Coverage includes mental health services provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities and psychologists endorsed as Health Services Providers in Psychology.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covers outpatient mental health/substance abuse services when the services are medically necessary for the diagnosis or treatment of the member's condition except when provided in an institution for mental diseases with more than 16 beds. Office visits limited to a maximum of 30 per a rolling 12 months per member without prior approval to a maximum of 50 visits per year.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Mental Health Rehabilitation-Community Centers	NO	Coverage includes outpatient mental health services, partial hospitalization (group activity program) and case management.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered services
Mentally Retarded Services-Intermediate Care Facilities **	NO	Non-covered for PCCM and RBMC members. Member must be disenrolled from Hoosier Healthwise managed care before benefit can begin. Medicaid coverage is available with preadmission diagnosis and evaluation. Includes room and board; mental health services; dental services; therapy and habilitation services; durable medical equipment; medical supplies; pharmaceutical products; transportation; optometric services.		
Nurse-midwife services	YES	Coverage is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for services rendered by a certified nurse-midwife when referred by a PMP. Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioners	YES	Coverage is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
Nursing Facility Services (Long-term)**	NO	Non-covered for PCCM and RBMC members. Member must be disenrolled from Hoosier Healthwise managed care before benefit can begin. Requires pre-admission screening for level of care determination and disenrollment from Hoosier Healthwise. Coverage includes room and board; nursing care; medical supplies; durable medical equipment; and transportation.		
Nursing Facility Services (Short-term)	YES	30 days maximum; must be prior to level of care determination.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services and conditions that may complicate the pregnancy or urgent care services.	

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Occupational Therapy** (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Cannot exceed 12 hours, sessions or visits in 30 calendar days.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.
Organ Transplants (405 IAC 5-3-13)	YES	Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered services
Orthodontics** (IHCP Provider Manual, pg. 8-261)	NO	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Out-of-state Medical Services** (405 IAC 5-5)	YES	Medicaid reimbursement is available for the following services provided outside Indiana: acute hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; and durable medical equipment and supplies. All out-of-state services are subject to the same limitations as in-state services.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covers acute, general hospital care; physician services; dental services; pharmacy services; transportation services; therapy services; podiatry services; chiropractic services; durable medical equipment and supplies. Coverage is subject to any limitations included in the CHIP benefit package.
Physicians' surgical and medical services*	YES (Except Psychiatrists and Behavioral Health Specialists)	Coverage includes reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 4 per month or 20 per year per member without prior authorization.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covers reasonable services provided by a M.D. or D.O. for diagnostic, preventive, therapeutic, rehabilitative or palliative services provided within scope of practice. PMP office visits limited to a maximum of 30 per year per member without prior authorization.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Physical Therapy** (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge. Cannot exceed 12 hours, sessions or visits in 30 calendar days.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per year, per type of therapy.
Podiatrists (405 IAC 5-26)	YES (Self-referral)	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. No more than six routine foot care visits per year are covered.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Surgical procedures involving the foot, laboratory or x-ray services, and hospital stays are covered when medically necessary. Routine foot care services are not covered.
Psychiatric Residential Treatment Facility (PRTF)	NO	Reimbursement is available for medically necessary services provided to children younger than 21 years old in a PRTF. Reimbursement is also available for children younger than 22 years old who began receiving PRTF services immediately before their 21st birthday. All services require prior authorization.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Non-covered.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Rehabilitative Unit Services - Inpatient** (405 IAC 5-32)	YES	The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function, or self-care activities.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covered up to 50 calendar days per calendar year.
Respiratory Therapy* (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for inpatient or outpatient hospital, emergency, and oxygen in a nursing facility, 30 calendar days following discharge from hospital when ordered by physician prior to discharge.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year (407 IAC 3-8-2), per type of therapy.
Rural Health Clinics	YES	Coverage is available for services provided by a physician, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Coverage is available for services provided by a physician, physician assistant, nurse practitioner, or appropriately licensed, certified, or registered therapist employed by the rural health clinic.

Table 2.4 - Hoosier Healthwise Program Description and Covered Benefits				
Benefit	**Reimbursed Under RBMC**	**Package A Standard Plan**	**Package B Pregnancy Coverage Only**	**Package C Children's Health Plan**
Speech, Hearing and Language Disorders* (405 IAC 5-22)	YES	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Prior authorization is not required for initial evaluations, or for services provided within 30 calendar days following discharge from a hospital when ordered by physician prior to discharge.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Services must be ordered by a M.D. or D.O. and provided by qualified therapist or assistant. Maximum of 50 visits per rolling year, per type of therapy.
Transportation - Emergency* (405 IAC 5-30)	YES	Coverage has no limit or prior approval for emergency ambulance or trips to/from hospital for inpatient admission/discharge, subject to the prudent layperson standard	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Covers emergency ambulance transportation using the prudent layperson standard as defined in 407 IAC 1-1-6. $10.00 co-payment applies.
Transportation – Non emergent (405 IAC 5-30)	YES	Non-emergency travel is available for up to 20 one-way trips of less than 50 miles per year without prior authorization.	Coverage is limited to services related to pregnancy (including prenatal, delivery, and postpartum services), as well as conditions that may complicate the pregnancy or urgent care services.	Ambulance services for non-emergencies between medical facilities are covered when requested by a participating physician; $10.00 co-payment applies. Any other non-emergent transportation is not covered.