

OHIO MEDICAID BENEFIT PLAN OVERVIEW

Service	Fee-For-Service ⁽¹⁾
Out-of Network	
Non-participating providers	<p>Services are not covered.</p> <ul style="list-style-type: none"> Ohio Medicaid is an any willing provider program. Eligible providers within and outside Ohio may submit an enrollment application. Once enrolled, providers may offer medically necessary services to Medicaid consumers.
In Network	
Allergy Testing and Treatment	<ul style="list-style-type: none"> Testing and treatment for allergies \$0 copay
Chiropractor services	<ul style="list-style-type: none"> 30 visits every 12 months (children < 21) 15 visits every 12 months (adults ≥ 21) \$0 copay
Audiology services	<ul style="list-style-type: none"> Hearing aids with prior authorization <ul style="list-style-type: none"> Conventional, digital and programmable hearing aids (children < 21) Conventional hearing aids (adults ≥ 21) One conventional hearing aid every four years; one digital or programmable hearing aide every five years \$0 copay
Dentist services	<ul style="list-style-type: none"> One exam and cleaning every six months One exam and cleaning every 12 months (adults ≥ 21) Dentures every eight years with prior authorization Crowns Root canals Braces in extreme cases with prior authorization (children < 21) \$3 copay per visit (Non-Pregnant adults ≥ 21 not residing in a NF or ICF/MR)
Optometrist and ophthalmologist services	<ul style="list-style-type: none"> One exam and eyeglasses every 12 months (individuals < 21 and ≥ 60) One exam and eyeglasses every 24 months (adults 21 to 59) Contact lenses with prior authorization Glaucoma screening \$2 copay for exam and \$1 for eyeglasses (adults ≥ 21 not residing in a NF or ICF/MR)
Physical therapy, occupational therapy, and speech/language pathology services	<ul style="list-style-type: none"> 30 visits for physical and occupational therapy combined every 12 months with prior authorization for additional visits 30 visits for speech/language and audiology services combined every 12 months with prior authorization for additional visits \$0 copay
Developmental therapy	<ul style="list-style-type: none"> Children to 6 years of age \$0 copay
Urgent Care	<ul style="list-style-type: none"> \$0 copay
Transportation services	<ul style="list-style-type: none"> Non-emergency transportation to and from Medicaid-covered services through the County Department of Job and Family Services Wheelchair van (prior authorization not normally required; certification of necessity required) Ambulance (prior authorization not normally required; certification of necessity required for non-emergency use) \$0 copay

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Diabetic Supplies and Insulin	<ul style="list-style-type: none"> • All diabetic supplies covered with limits on quantity • Insulin pump • \$0 copay
Dietitian Services	<ul style="list-style-type: none"> • \$0 copay
Durable medical equipment (DME)	<p>Covered DME items include</p> <ul style="list-style-type: none"> • Wheelchairs • Canes, crutches and walkers • Lifts • Oxygen supplies • Ventilators • Speech generating devices • Incontinence garments • Bedside commodes • Ostomy supplies • Lactation pump <ul style="list-style-type: none"> • Some items require prior authorization • \$0 copay
Emergency Room	<ul style="list-style-type: none"> • \$3 copay for non-emergency services (Non-Pregnant adults \geq 21 not residing in a NF or ICF/MR)
Preventive Exams and Screenings	<p>Services include</p> <ul style="list-style-type: none"> • Gynecologic exams • Employment physicals if not covered by another source • Required physician visits for long-term-care-facility residents • Cervical cancer screenings • Prostate cancer screenings • Colonoscopy for adults \geq 50 or high risk <ul style="list-style-type: none"> • \$0 copay
Healthchek (EPSDT) ⁽¹⁾	<ul style="list-style-type: none"> • Individuals < 21 • 13 well-child visits by age three and then one every 12 months • Comprehensive health and developmental history • Diagnosis and treatment identified as necessary during screening examinations • \$0 copay
Immunizations	<ul style="list-style-type: none"> • Vaccines as recommended by the Centers for Disease Control, American Academy of Pediatrics and Advisory Committee on Immunization Practices • Annual flu and pneumonia shots • \$0 copay
Laboratory and X-ray services	<ul style="list-style-type: none"> • Medically necessary services ordered by a physician • Annual chest x-rays for long-term-care-facility residents • Mammograms • \$0 copay
Home health services	<p>Services include</p> <ul style="list-style-type: none"> • Home health nursing • Home health aide • Physical and Occupational Therapy • Speech-Language Pathology <ul style="list-style-type: none"> • Requires face-to-face encounter with physician prior to certification of medical necessity • Services must be \leq four hours per visit, \leq eight hours per day and \leq 14 hours per week • \leq 28 hours per week for up to 60 days in limited circumstances • Increased services in specified situations for children < 21 and requiring Healthchek related services • \$0 copay

Service	Fee-For-Service ⁽¹⁾
Private duty nursing services	<ul style="list-style-type: none"> • Nursing visits from four to 12 hours in length • Can be > four hours per visit or up to 16 hours per day in limited circumstances • Post-hospital stay benefit with ≤ 56 hours per week for ≤ 60 days • Prior authorization required • \$0 copay
Home and community-based services (e.g., PASSPORT, Ohio Home Care, Individual Options and Assisted Living waivers)	<p>Examples of services (not all services available on all waivers)</p> <ul style="list-style-type: none"> • Personal care • Waiver nursing • Respite care • Social work and counseling • Meals and nutrition counseling • Home modification • Transportation • Must meet level of care requirements • Special income maintenance needs allowance plus ≤ \$65 depending on employment status • Patient liability amount depends on income and special income maintenance needs allowance
Hospice services	<p>Services include</p> <ul style="list-style-type: none"> • Routine home care • Continuous care • Inpatient respite care • General inpatient care • Nursing Facility and ICF/MR Room and Board • Can include curative treatment for children < 21 • \$0 copay
Inpatient hospital services	<ul style="list-style-type: none"> • ≤ 30 covered days from the date of admission to 60 days after discharge with limited exceptions • Prior approval may be needed for some surgeries • Chemical dependency detoxification • \$0 copay
Outpatient hospital services	<ul style="list-style-type: none"> • Medical review for > 48 visits per year • Prior approval may be needed for some surgeries • \$0 copay
Physician services	<ul style="list-style-type: none"> • Up to 24 visits every 12 months with additional visits for specified conditions • Pediatric and family nurse practitioner services • \$0 copay
Pregnancy-Related Services	<ul style="list-style-type: none"> • All pregnancy related services are covered. Services include: <ul style="list-style-type: none"> • Education • Care coordination • Counseling • High risk monitoring • Nurse midwife services • Preconception care • Prenatal care • Ultrasounds • Prenatal risk assessment • Delivery • Transportation • \$0 copay
Family planning services and supplies	<ul style="list-style-type: none"> • As needed • \$0 copay

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Podiatrist services	<ul style="list-style-type: none"> • One long-term-care facility visit per month • One nail debridement per 60 days • \$0 copay
Prosthetics and Orthotics	<ul style="list-style-type: none"> • Up to two pairs of shoes per 365 days (individuals ≥ 8) • Up to three pairs of shoes per 365 days (children < 8) • \$0 copay
Nursing facility (NF) services	<ul style="list-style-type: none"> • Must meet level of care requirements • Must meet PASRR requirements • ≤ 30 bed hold days per calendar year in specified situations • \$40 or \$105 maximum monthly personal needs allowance depending on income and employment status • Patient liability depends on income, personal needs allowance, and other factors
Intermediate Care Facility for persons with Mental Retardation (ICF/MR) services	<ul style="list-style-type: none"> • Must meet level of care requirements • ≤ 30 bed hold days per calendar year in specified situations (additional days require prior authorization) • \$40 or \$105 maximum monthly personal needs allowance depending on income and employment status • Patient liability depends on income, personal needs allowance, and other factors
Community behavioral health services	<p>Services include</p> <ul style="list-style-type: none"> • Behavioral health counseling • Mental health assessment • Pharmacologic management • Crisis intervention • Community psychiatric support treatment • Partial hospitalization in specified circumstances <ul style="list-style-type: none"> • \$0 copay
Independent psychologist services	<ul style="list-style-type: none"> • Up to eight hours psychological testing every 12 months • Up to 25 visits every 12 months • \$0 copay
Prescription drugs	<ul style="list-style-type: none"> • ≤ 34 day supply dispensed at a time for drugs to treat acute conditions • ≤ 120 day supply dispensed at a time for drugs to treat chronic conditions • Prior authorization required for name-brand when generic is available • \$3 copay for drugs requiring prior authorization (non-pregnant and non-institutionalized adults ≥ 21) • \$2 copay for most name-brand drugs (non-pregnant and non-institutionalized adults ≥ 21) • \$0 copay for hospice consumers and medications for emergency services and family planning services
Noncovered services	<p>The following services are NOT covered</p> <ul style="list-style-type: none"> • Services determined not medically necessary by Medicaid, Medicare or another third-party payer • Abortion with limited exceptions • Infertility services • Drugs to treat erectile dysfunction • Paternity testing • Inpatient rehabilitation for chemical dependency • Cosmetic surgery for aesthetic purposes • Services related to forensic studies • Acupuncture • Biofeedback services • Research or experimental services • Autopsy • Patient convenience items • Pregnancy services related to a surrogate pregnancy