







**Mountain Health Choices
Plan C - Children**

Medicaid Benefits at a Glance		
Benefit Description	Basic (Children)	Enhanced (Children)
Well Child Visits (EPSDT Services)	Covered	Covered
Inpatient Hospital Care	Prior Auth Required	Prior Auth Required
Inpatient Hospital Rehabilitation	Prior Auth Required	Prior Auth Required
Inpatient Hospital Psychiatric Services	Prior Auth Required - maximum benefit of 30 days/year	Prior Auth Required
Outpatient Surgery/Services	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Diagnostic x-ray, laboratory services and testing	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Primary Care Office Visits	Covered	Covered
Physician Office Visits - Specialty Care	Covered	Covered
Birth to Three Services	Covered	Covered
Occupational/Speech/Physical Therapy	Covered - maximum benefit of 20/year (total allowed for all therapies combined) (Prior Auth Required)	Covered (Prior Auth Required)
Weight Management	Not Covered	Covered 
Home Health Services	Covered - maximum benefit of 25/year	Covered
Durable Medical Equipment	Covered - limited to \$1000 per year with Prior Auth required if limit exceeded (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Non-emergency Medical Transportation	Covered - 10/year (5 round trips)	Covered
Ambulance Services	Covered	Covered
Prescriptions	Limited - 4 per month	Covered
Hospice	Covered	Covered
Vision Services	Comprehensive eye exam, glasses - maximum benefit of \$750/year	Comprehensive eye exam, glasses, contact lenses, vision training 
Emergency Dental Services	Covered	Covered
Dental Exams (dental check-ups)	Covered - 2/year	Covered
Hearing Services/Aids/Supplies	Annual exam and hearing aids when medically necessary	Covered
Orthotics and Prosthetics	Covered (Prior Auth Required for Certain Services)	Covered (Prior Auth Required for Certain Services)
Tobacco Cessation Programs	Covered	Covered
Family Planning	Covered	Covered
Cardiac Rehabilitation	Covered (Prior Auth Required)	Covered  (Prior Auth Required)
Pulmonary Rehabilitation	Covered (Prior Auth Required)	Covered  (Prior Auth Required)
Chiropractic Services	Not Covered	Not Covered
Podiatry Services	Not Covered	Covered
Chemical Dependency/Mental Health Services (limited)	Covered - maximum benefit of 26/year (Prior Auth Required)	Covered (Prior Auth Required)
Diabetes Education/Nutritional Counseling	Covered	Covered 
Nutritional Education Services	Not Covered	Covered 
Skilled Nursing Care (Private Duty Nursing)	Not Covered	Covered (Limited to 180 days/yr --Prior Auth Required)

***Medically necessary services, as set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)) and identified by an EPSDT (early and periodic screening, diagnostic and treatment services) screen will be provided either at the medical home or referred to an appropriate provider.**