Medical Benefit Comparison
Arizona State Employee Medical Benefits compared to AHCCCS Acute Care Title XIX Members

(Excludes Consideration of additional services available to Medicare members)

Prepared by OMP June 2006 - Update 2-13-09

Covered Services

		Medical Policy Coverage	Coverage Differences	
Service	**State Employee**	**AHCCCS Acute Care**	**State Employee Plan provides greater coverage**	**AHCCCS provides greater coverage**
Key		✓ = Substantially equivalent service provided by AHCCCS. EPSDT = AHCCCS Members under age 21.	N/A = Not applicable	N/A = Not applicable
Allergy Screening	Covered Service, $20 copay required (pg 36)	✓	N/A	N/A
Antigen Administration Desensitization/treatment	Covered Service, $20 copay required (pg 36)	✓	N/A	N/A
Breast reconstruction and Breast Prostheses	Following a mastectomy the following services and supplies are covered: 1) Surgical services for reconstruction of the breast on which the mastectomy was performed 2) Surgical services for reconstruction of the non-diseased breast to produce symmetry. 3) Post-operative breast prosthesis and 4) Mastectomy bras/camisoles and external prosthetics that meet external prosthetic placement needs. Bras/camisoles are limited to two articles per member per plan year. (pg 47)	Breast reconstruction following medically necessary mastectomy is covered. Contralateral breast modification is also covered.	N/A	N/A
Cancer Clinical Trials	Coverage shall be provided for medically necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the member participates voluntarily. (pg 48)	A service that is considered experimental or provided primarily for the purpose of research is not covered. (R9-22-201 B 10 a) AHCCCS members may participate in experimental treatment.	N/A	N/A
Case Management	Available on a voluntary basis. (pg 33)	✓	N/A	N/A
Chiropractic care and osteopathic manipulation	Chiropractic care services include diagnostic and treatment services utilized in an office setting by participating chiropractic physician and osteopaths. $10 copay - Limited to 20 visits per participant per year for children and adults (pg 50 and 36.)	Adult - Not Covered	Chiropractic care is covered for adults with a limit of 20 visits per year.	N/A
Chiropractic care - EPSDT		EPSDT - Covered (Policy 430-14)	N/A	Chiropractic care is covered for EPSDT members without a maximum number of visits. Therefore, potentially greater benefit.

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Cochlear Implant	Covered Service (Determined through discussion with ADOA representative).	✓	N/A	N/A
Cosmetic Surgery	Cosmetic surgery is covered for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Congenital defects and birth abnormalities are covered for eligible dependent children. (pg 50) Although, cosmetic surgery is listed as covered in State Employee Health Plan, the limits are such that substantive policy is the same as AHCCCS.	Services furnished solely for cosmetic purposes are excluded. (R9-22-205)	N/A	N/A
Diabetic Supplies	Coverage will be provided for the following medically necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes: (pg51-52) 1. Podiatric/appliances for prevention of complications with diabetes; foot orthotic devices and inserts (therapeutic shoes: including depth shoes of custom molded shoes.) Custom molded shoes will only be covered when the member has a foot deformity that cannot be accommodated by a depth shoe. Therapeutic shoes are covered only for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history of preulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation. 2. Any other device, medication, equipment or supply for which coverage is required under Medicare guidelines pertaining to diabetes management; and (the following supplies are individually listed and are available through mail order: insulin, lancets, insulin syringes/needles, prefilled cartridges, urine test strips, blood glucose testing machines, blood sugar test strips, and alcohol swabs.)	✓	N/A	N/A

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	3. Charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following: a) Medically necessary visits when Diabetes is diagnosed; b) Visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management; c) Visits when reeducation or refresher training is prescribed by the Physician; and d) Medical nutrition therapy (education) related to diabetes management.			
Diagnostic testing including laboratory and radiology.	Diagnosis testing includes radiological procedures, laboratory tests, and other diagnostic procedures. (pg 52)	✓	N/A	N/A
Dialysis	Covered Service (pg 47)	✓	N/A	N/A
Disease Management	Available on a voluntary basis. (pg 33)	✓	N/A	N/A
Durable Medical Equipment (DME)	Such equipment includes, but is not limited to crutches, hospital beds (to maximum of $5,000), wheel chairs, respirators and dialysis machines.	✓	N/A	Hospital bed limit to $5,000 maximum for state employee. AHCCCS does not have a specific limit.
Durable Medical Equipment (DME) Repair	Coverage for repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to anatomical growth or a change in medical condition. (pg 52-53)	Reasonable repair or adjustment of purchased DME is covered if necessary to make the DME serviceable and if the cost of repair is less than the cost of renting or purchasing another unit. (R9-22-212-E-2)	N/A	Required repair of DME is covered by AHCCCS. State employees have a limit of $5,000 on hospital beds.
Emergency Room	Copay = $125, waived if admitted. Must be a medical emergency as defined by the plan. (See below) (pg 38) Emergency services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required for the relief of acute pain, for the initial treatment of acute infection or to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. (pg 46)	✓ Medical emergency is defined by R9-22-Article 2 and BBA regulations as interpreted by AHCCCS and Plan.	N/A	N/A

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Emergency: Out-of-Area	Copay = $125, waived if admitted. Must be a medical emergency as defined by the plan. (See above) (pg 38)	✓	N/A	N/A

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Family Planning Services	Tubal ligation: No copay (pg 37) Vasectomy (Physician's office) $20 copay Implantable contraceptive products (one every 5 years). Contraceptive Appliances obtained at a physician's office: $10 copay Prescription Medication	✓ ✓ ✓ allowable every 2 years ✓ ✓	N/A	N/A
Family planning extension services	Coverage is excluded for any service after the termination date of the member.	Members whose SOBRA eligibility postpartum eligibility has expired (ARS 36-2907.04) are eligible to receive family planning extension service for up to 24 months. Family planning extension services include only those services related to family planning; other services are not covered. (Covered services include contraceptive counseling, medication, supplies, including, but not limited to : oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories. (Policy 420-1)	N/A	Family planning extension services are available to women beyond their AHCCCS eligibility.
Hearing Aids - Adults	Limited to $2,000 per participant per plan year (pg 40)	Adult - Not Covered (policy 310-1)	Hearing aids are a covered benefit for State employees with a limit of $2,000 per year.	
Hearing Aids - EPSDT		EPSDT - Covered (policy 430-3)		Hearing aids are covered for EPSDT there is not a stated annual limit. In State employee plan limit is $2,000.
Hearing Screening	$10 copay (one per member per plan year. Pg 40	AHCCCS covers medically necessary audiology services to evaluate hearing loss for all members on both an inpatient and outpatient basis. (policy 310-1)	N/A	N/A
Home Health / Home Infusion Care	Home Health services are covered when member requires skilled care, are unable to obtain the required care as an ambulatory outpatient and do not require confinement in a hospital or other health care facility. (pg 54)	✓	N/A	N/A
Hospice Care - Adult	Hospice is covered when provided under an approved hospice care program when the Member has been diagnosed by a Participating Provider as having a terminal illness with a prognosis of six (6) months or less to live. (pg 56)	✓	N/A	N/A
Hospice Care - EPSDT		✓	N/A	N/A

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Hospital (inpatient)	Inpatient hospital services are services provided for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in another participating health care facility. Inpatient hospitals also include birthing centers. (pg 45)	✓	N/A	N/A
Immunizations	Age appropriate immunizations are covered for adults and children. (pg 36) $10.00 copay applies (In some instances the copay is waived for children)	✓	N/A	N/A
Infertility treatment	Covered with 50% coinsurance	Not a covered benefit (policy 420-3)	Infertility treatment is covered up to limits in policy.	N/A
Infertility visits	visits: $20 copay: subject to medical necessity guidelines. (pg 37) The following are specifically excluded infertility services: 1) Infertility drugs 2) In-vitro fertilization; 3) Gamete intrafallopian transfer (GIFT) 4) Zygote intrafallopian transfer (ZIFT) and variations of these procedures 5) Any costs associated with the collections, washing, preparation, or storage of sperm for the non-covered assisted reproduction procedures listed above, as well as costs associated with the storage of sperm or sperm donor fees for artificial insemination 6) Reversal of voluntary sterilizations 7) Infertility services when the infertility is caused by or related to voluntary sterilization 8) Ovarian transplant 9) Cryopreservation of donor sperm and eggs 10) Charges related to a surrogate 11) Any experimental or investigational infertility procedures or therapies. (56-57)	Not a covered benefit (policy 420-3)	Infertility visits are covered subject to copay.	N/A
Intensive Care Unit	Covered Service (pg 35)	✓	N/A	N/A
Laboratory	Diagnostic testing including laboratory tests are covered. (pg 50)	✓	N/A	N/A

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Mammography screening	Age 35-39, one baseline One per year over 40 (pg 57)	AHCCCS covers routine annual mammography screening beginning at age 50. Mammography is covered at any age if considered medically necessary. (policy 310-13)	State Employee benefit may be considered a richer benefit as routine screening begins at an earlier age.	N/A
Maternity - Physician Prenatal care and program	$10 copay for initial diagnosis, 100% thereafter (pg 37)	✓	N/A	N/A
Maternity – Hospital	Covered Service (pg 58)	✓	N/A	N/A
Medical foods /metabolic supplements and Gastric Disorder Formula	The plan covers metabolic supplments and Gastric Disorder Formula for individuals who have an inherited medical disorder or a permanent disease/non-functioning coundition in which a Member is unable to sustain weight and strength commensurate with the Member's overall health status are covered. (pg 59) The plan will cover up to 75% of the cost of medical foods prescribed to treat metaolic disorders covered under this Plan. There is a maximum plan year limit for medical foods of $20,000 which applies to the cost of all prescribed modified low protein foods and metablic formula. pg 59	AHCCCS covers medical foods for adults and children with an inherited metabolic condition. There is no maximum annual benefit nor coinsurance payment required. (Policy 320-18)	N/A	AHCCCS covers without coinsurance or an annual maximum.
Midwife	Services rendered by a midwife for the purpose of home delivery are excluded. (pg 76) Per ADOA clarification services would be covered at a birthing center.	AHCCCS covers labor and delivery services provided in the home by licensed physicians, practitioners (physician assistants, or certified nurse practitioners in midwifery) and licensed midwifes. (410-10) AHCCCS covers maternity care and coordination provided by licensed midwives within their scope of practice. Licensed midwife services may only be provided to member for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. (410-11)	N/A	Licensed midwife service is covered subject to certain limitations for home delivery.

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Nutritional Evaluation - Adult	Nutritional evaluation and counseling from a participating provider is covered when diet is a part of the medical management of a documented organic disease, including morbid obesity. (pg 63)	✓	N/A	N/A
Nutritional Evaluation - EPSDT		EPSDT - AHCCCS covers the assessment of nutritional status provided by PCP and by a registered dietician when ordered by the member's PCP. (430-6)	N/A	N/A
Orthognathic Procedure - Adult	Benefits are payable to treat TMJ disorder with is a result of : An accident, trauma congenital defect, developmental defect or a pathology. Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are not covered. (pg 67)	Adults - Orthognathic surgery is not covered for adults. However, AHCCCS may cover in stated circumstances.	It appears that State Employees may have greater coverage for adults, but it is limited, and potentially AHCCCS would also cover in stated circumstances.	
Orthognathic Procedure - EPSDT		EPSDT - Orthognathic surgery is covered when medically necessary. (Policy 430-12)		AHCCCS may allow greater coverage for orthognathic surgery for EPSDT population.
Orthotics	Foot orthotics are covered for diabetic member only. (54) Clarified by ADOA representative.	Orthotic/prosthetic devices that are essential to the rehabilitation of the member are covered. (Policy 310-25)	N/A	AHCCCS may allow greater coverage for orthotics as policy does not require that member be diabetic.
Periodic routine physical exams	$10 copay			

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Well-child (and immunization)	Well child visits and immunizations are covered through age 1 as recommended by the American academy of Pediatrics. (65). For age 2and older routine periodic health exams are covered annually.	✓	N/A	N/A

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Well-man care	Well man exams are covered in addition to periodic health exams. Covered expenses include an annual office visit with prostate-specific antigen (PSA) test. Laboratory charges are covered as a separate expense. Limited to 1 visit per Member per plan year, limit to $1,500 maximum benefit per plan year (pg 66)	✓	N/A	N/A
Well-woman care	Well woman exams are covered in addition to periodic health exams. Covered expenses include an annual office visit and one Papanicolaou test (PAP smear). Laboratory charges are covered as a separate expense. Limited to 1 visit per Member per plan year. (pg 65)	✓	N/A	N/A
Physician inpatient visit	Covered service, no copay (pg 35)	✓	N/A	N/A
Physician office visit	$10 copay, specialists $20. (35) Physician services are diagnostic and treatment services provided by participating physicians and other participating health professionals including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures. (pg 45)	✓	N/A	N/A
Prescription Medication	Prescription medications are covered with the following copays: (pg 40) <u>Mail order (90 days)</u> Generic: $20	✓	N/A	N/A

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	Formulary brand: $40 Non-formulary brand: $80 Infertility – oral medication $80 Retail pharmacy Generic: $10 Formulary brand: $20 Non-formulary brand: $40 Infertility – oral medication $10 Smoking cessation $500 maximum lifetime			
Prosthetic Appliances	Plan covers the initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect. (pg 53 and 54)	Orthotic/prosthetic devices that are essential to the rehabilitation of the member are covered. (Policy 310-25)	N/A	N/A
Diagnostic testing including laboratory and radiology	Covered service no copays (36)	✓	N/A	N/A
Rehabilitation **(outpatient)**	Short-term rehabilitative therapy includes services in an outpatient facility or physician's office that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy. Covered expenses are limited to 60 visits per Member per Plan Year (inclusive of all therapies). Copay is $10.00 per visit. (pg 66) Policy is applicable to children and adults.	For AHCCCS coverage for outpatient Rehabilitation Service by population see below.		For all of the outpatient therapies, if service is covered, there is no stated limit in the number of visits that are allowed and no copay required.
Physical Therapy - Adult (outpatient)		Adults - Covered (policy 310-47)	N/A	AHCCCS covers without a limit on number of visits.
Physical Therapy - EPSDT (outpatient)		EPSDT - Covered	N/A	AHCCCS covers without a limit on number of visits.
Occupational Therapy - Adult (outpatient)		Adults - Not Covered (policy 310-46)	Outpatient OT is covered for Adult State Employees subject to limits of policy.	N/A
Occupational Therapy - EPSDT (outpatient)		EPSDT - Covered	N/A	AHCCCS covers without a limit on number of visits.
Speech Therapy - Adult (outpatient)		Adults - Not Covered (policy 310-48)	Outpatient speech therapy is covered for Adult State Employees subject to limits of policy.	N/A
Speech Therapy - EPSDT (outpatient)		EPSDT - Covered	N/A	AHCCCS covers without a limit on number of visits.

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Pulmonary Rehab Therapy (Adult and EPSDT) (outpatient)		AHCCCS does not overtly cover pulmonary rehab but to the extent that physical therapy is covered, pulmonary rehab therapy would be covered.	Pulmonary rehab is covered as a distinct service subject to limits of policy.	N/A
Cardiac Rehabilitation Therapy (Adult and EPSDT) (outpatient)		AHCCCS does not overtly cover cardiac rehab but to the extent that physical therapy is a component cardiac rehab therapy would be covered.	Cardiac rehab is covered as a distinct service subject to limits of policy.	N/A
Skilled Nursing Facility	Coverage includes up to 90 days of skilled nursing facility/Rehabilitation hospital or sub-acute facility per member per plan year (pg 39)	AHCCCS covers up to 90 days of Nursing Facility services per contract year. (policy 310-29)	N/A	N/A
Supplies, Medical	Medical supplies include medically necessary supplies which may be considered disposable however, are required for a Member in a course of treatment for a specific medical condition. Supplies must be obtained from a Participating Provider. Over the counter supplies, such as band-aides and gauze are not covered. (pg 60)	✓	N/A	N/A
Incontinence Briefs - Adult	Per discussion ADOA representative, incontinence briefs would not be covered for adults or children.	Acute Care Adult - Covered if medically necessary to treat skin breakdown	N/A	Acute Adults - Under limited circumstances incontinence briefs are covered for adults.
Incontinence Briefs - EPSDT		EPSDT - Incontinence briefs are covered for EPSDT members who have a disability that causes incontinence. Member must be age 3 or older. Benefit is limited to 240 briefs per month. (policy 430-15)	N/A	EPSDT - Incontinence briefs are covered for EPSDT members who have a disability that causes incontinence.
Surgery Facility and Associated physician fees	In physician's office: $10 copay In freestanding ambulatory facility: no charge In hospital outpatient surgical center facility: no charge (pg 38)	✓	N/A	N/A
Surgery & Anesthesia	Covered Service no copays apply (pg 36)	✓	N/A	N/A
Gastric Bypass Surgery	Gastric bypass surgery is an excluded service except for specifically identified conditions of disease etiology. (pg 74 and 75)	Gastric bypass surgery is covered when medically necessary subject to guidelines established by AHCCCS and/or Contractors.	N/A	N/A

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Total Parenteral Nutrition	Covered Benefit	AHCCCS follows Medicare guidelines for the provision of TPN services. (policy 310-52)	N/A	N/A
Transplant: Organ and Tissue	Human organ and tissue transplant services are covered at designated facilities throughout the United Stated. Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. (pg 64)	✓	N/A	N/A
Transplant: Organ and Tissue (Travel and Lodging)	Travel and lodging are limited to $10,000 per transplant. Travel expenses will also be covered for one companion. (pg 64 and 65) Travel costs within 60 miles of member home are excluded.	AHCCCS covers transportation for the transplant recipient and, if needed, one adult caregiver to an from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center. (Policy 310-69)	N/A	AHCCCS doses not impose a limit on travel and lodging expense associated with travel.
Transportation (Non-emergency) Ambulance	Non-emergency ambulance transportation requires pre certification. Per clarification ADOA, this would generally be related to interfacility transfer which is covered. (pg 38)	✓	N/A	N/A
Transportation (Non-emergency) Non-ambulance	Per discussion ADOA representative, transportation by taxi is not covered.	Medically necessary transportation is covered for members who are unable to arrange transportation to a service site or location (R9-22-211)	N/A	AHCCCS provides greater coverage for non-emergency transport.
Transportation (Emergency) Ambulance (for medical emergency or required inter-facility transport)	Covered expenses include charges for a licensed ambulance service to or from the nearest hospital where the needed medical care and treatment can be provided. (pg 47)	Emergency transportation is covered by ambulance. Air ambulance is covered when the needs of member will not be served by ground ambulance. (policy 310-53)	N/A	N/A
Urgent care center	Covered, requires a $20 copay. (pg. 38)	✓	N/A	N/A

Dental	State employees have the option to purchase dental service in addition to medical coverage. Comparison below relates only to dental services provided in State Employee medical coverage plan			

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Limited Dental Services (Accident/Emergency)	Dental services are covered for the treatment of a fractured jaw or an injury to sound natural teeth. Services are payable for a physician dentist, or dental surgeon provided the services are rendered for treatment of an accidental injury to sound natural teeth where the continuous course of treatment is started within six months of the accident. (pg 51)	Medically necessary emergency dental care and extractions are covered for all members who have a malady that meets the definition of an emergency medical cognition. (Policy 310-6)	N/A Both the State Employee plan and AHCCCS plan provide dental coverage for narrowly defined conditions. State Employee plan covers dental service following an accident. AHCCCS covers in an emergency.	N/A
Dentures - Adult	Dentures are specifically excluded as a covered benefit. (pg 76)	Adult - Medically necessary dentures are covered. (policy 310-5)	N/A	Medically necessary dentures are covered for adults.
Dentures - EPSDT		EPSDT - Dentures, orthodontics and orthognathic surgery is covered when medically necessary and determined to be the primary treatment of choice or an essential part of the overall treatment plan designed by the PCP in consultation with the dentist. (Policy 430-12)	N/A	Medically necessary dentures are covered for EPSDT members.
Prevention and Therapeutic - Adult	Not Covered Benefit (pg 74)	Adult - Not a covered benefit	N/A	N/A
Prevention and Therapeutic - EPSDT		EPSDT - Preventative and Therapeutic dental services are covered for EPSDT members. (policy 430- pg 9 - 12)	N/A	AHCCCS covers preventative and therapeutic dental service for EPSDT members.
Vision	State employees have the option to purchase vision coverage in addition to medical coverage. Comparison relates only to vision services provided in State Employee medical coverage plan			
Eyeglass lenses and frames and contact lenses - Adult	Excluded except for the first pair of contacts for treatment of keratoconus or post -cataract surgery. Excluded routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy. (pg 76)	Acute Care Adult - Prescriptive lenses are excluded except following medically necessary cataract removal. (policy 310-11)	N/A	N/A

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Eyeglass lenses and frames and contact lenses - EPSDT		EPSDT - Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screening. (policy 430-5)	N/A	EPSDT - AHCCCS covers prescriptive lenses.
Vision Care - Adult	Medical Coverage - Covered. Included in annual well visit. Maximum benefit for well visit, hearing, and vision is $1500 annual. Per clarification ADOA, medical condition of the eye would be covered. Issues requiring prescriptive lenses are not covered.	Acute Care Adult - Emergency eye care is covered for all members. Vision examinations are only covered for adults following medically necessary cataract removal. (Policy 310-11) Any medical condition of the eye would be covered within AHCCCS for adults and children	Acute Care Adult - State Employee plan covers vision screening for adults, however, per discussion ADOA, this is limited coverage.	N/A
Vision Care - EPSDT		EPSDT - Eye examinations appropriate to age are covered. (Policy 430-5) Medical condition of the eye would also be covered.	N/A	N/A
Behavioral Health **Mental health and substance abuse (inpatient)**				
Inpatient Hospital Services	Covered, no limit on days	✓	N/A	N/A
Inpatient psychiatric facility services	Covered, no limit on days	✓	N/A	N/A
Residential substance abuse treatement	Voluntary and court-ordered residential substance abuse treatment will be covered for a maximum of 30 days and limited to two treatments per plan year for chemical and alcohol dependency. (61)	AHCCCS covers Behavioral Health Residential Services (See Policy G)	N/A	AHCCCS provides coverage for Behavioral health residential services.
Mental Health and substance abuse (outpatient)	$10 copay		See below	See below

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examples of covered therapies are listed below:	Excluded: Treatment for mental disorder that has been diagnosed as organic mental disorder associated with permanent dysfunction of the brain and; Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain. (62) Per clarification with ADOA representative, there appears to be no service that could be identified that would be excluded. Per ADOA representative there are very few limits on mental health coverage.			

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Individual therapy and counseling	Covered Service	✓	N/A	N/A
Group and/or family therapy and counseling	Covered Service	✓	N/A	N/A
Psychotropic Medication	Covered Service	✓	N/A	N/A
Psychotropic medication adjustment and monitoring	Covered Service	✓	N/A	N/A
Respite Care	Not Covered	Covered Service, Adults and EPSDT.	N/A	AHCCCS covers respite for adults and EPSDT within the Behavioral Health program.
Partial Care (supervised day program, therapeutic day program and medical day program	Not Covered	Covered Service, Adults and EPSDT.	N/A	AHCCCS covers partial care for adults and EPSDT within the Behavioral Health program.
Emergency crisis behavioral health services	Covered Service	✓	N/A	N/A
Behavioral management	Covered Service	✓	N/A	N/A
Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)	Excluded counseling for activities of an educational nature. Vocation or religious counseling. (pg 72)	Covered Service, Adults and EPSDT.	N/A	AHCCCS covers psychosocial rehabilitation for adults and EPSDT within the Behavioral Health program.
Screening and evaluation	Covered Service	✓	N/A	N/A
Lab and radiology services for diagnosis and psychotropic medication regulation	Covered Service	✓	N/A	N/A

Covered Services

	Medical Policy Coverage		Coverage Differences	
Service	**State Employee**	**AHCCCS Acute Care**	**State Employee Plan provides greater coverage**	**AHCCCS provides greater coverage**
Key		✓ = Substantially equivalent service provided by AHCCCS. EPSDT = AHCCCS Members under age 21.	N/A = Not applicable	N/A = Not applicable

Source:

Covered Services

	Medical Policy Coverage		Coverage Differences	
Service	**State Employee**	**AHCCCS Acute Care**	**State Employee Plan provides greater coverage**	**AHCCCS provides greater coverage**
Key		✓ = Substantially equivalent service provided by AHCCCS. EPSDT = AHCCCS Members under age 21.	N/A = Not applicable	N/A = Not applicable

State Employee Benefits	Susan Strickler, Benefits Manager, AZ Department of Administration (Personal communication 6/16/06) Plan Description, Harrington EPO Plan, effective October 1, 2004. Restated effective October 1, 2005 February 11, 2009 - Reviewed Plan Description, Harrington EPO Plan, effective October 1, 2007
AHCCCS Benefits	AHCCCS Medical Policy Manual AHCCCS Administrative Rule