



### Healthfirst NJ FamilyCare/Medicaid Benefit Grid 2011

<b>BENEFITS (Subject to policies and procedures)</b>	<b>MEDICAID &amp; NJ FAMILYCARE A</b>	<b>ABD MEMBERS</b>	<b>NJ FAMILYCARE B &amp; C</b>	<b>NJ FAMILYCARE D</b>
Abortion (Elective)	Medicaid FFS*	Medicaid FFS*	Medicaid FFS*	Medicaid FFS*
Acupuncture	COVERED	COVERED	COVERED	NOT COVERED Except for Anesthesia
Allergy Testing	COVERED	COVERED	COVERED	COVERED
Blood & Plasma Products	COVERED	COVERED	COVERED	NOT COVERED (except admin of blood, processing of blood, processing fees, and fees related to autologous blood donations are covered)
Bone Mass Measurement (Bone Density)	COVERED	COVERED	COVERED	COVERED
Care Management	COVERED	COVERED	COVERED	COVERED
Nurse Practitioner/Certified Nurse Midwife	COVERED	COVERED	COVERED \$5 copay for NJFC C only except prenatal visits (Nurse Midwife) or preventive care visits (Nurse Practitioners)	COVERED Nurse Midwife- \$5 copay for first prenatal visit; \$10 for services rendered during non-office hours and home visits. No copay for preventive services or newborns covered under FFS.  Nurse Practitioner- \$5 copay for each visit except for preventive care services. \$10 copay for non-office hour visits.
Chiropractor Services (Manual Manipulation of Spine)	COVERED	COVERED	COVERED (\$5 copay for NJFC C only)	NOT COVERED
Colorectal/Prostate Screening Exams (recommended for ages 50 and above)	COVERED	COVERED	COVERED	COVERED

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<b>BENEFITS (Subject to policies and procedures)</b>	<b>MEDICAID &amp; NJ FAMILYCARE A</b>	<b>ABD MEMBERS</b>	<b>NJ FAMILYCARE B &amp; C</b>	<b>NJ FAMILYCARE D</b>
Court Ordered Services	COVERED – Contact Healthfirst NJ	COVERED – Contact Healthfirst NJ	COVERED – Contact Healthfirst NJ	NOT COVERED
Dental Services	COVERED	COVERED	COVERED - (\$5 copay for NJFC C members except for preventive dental)	COVERED for children under the age of 19. (\$5 copay for each visit except for preventive services)
Diabetic Education	COVERED	COVERED	COVERED	COVERED
Diabetic Supplies	COVERED	COVERED	COVERED	COVERED
Durable Medical Equipment (DME)/ Assistive Technology Devices	COVERED	COVERED	COVERED	COVERED  But limited to the following equipment/devices:  Apnea Monitors Bathroom Equipment (Permanently Affixed Equipment Not Covered) Catheterization and Related Supplies Commodes DME Repairs Enteral Nutrition and Related Services/Supplies Hospital Beds ( Manual, Semi-Electric and Full Electric) and Related Equipment Insulin Pumps and Related Supplies Manual Wheelchairs (Motorized Wheelchairs Not Covered) Nebulizers and Related Supplies Ostomy / Ileostomy / Jejunostomy Supplies Oxygen and Related Equipment/Supplies Pacemaker Monitors

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BENEFITS (Subject to policies and procedures)	MEDICAID & NJ FAMILYCARE A	ABD MEMBERS	NJ FAMILYCARE B & C	NJ FAMILYCARE D
				Parenteral Therapy and Related Services / Supplies Patient Lifts and Related Equipment Pressure Mattresses / Pads (Low Air Loss and Air Fluidized Beds Not Covered) Respiratory Assist Devices and Related Supplies Suction Machines and Related Supplies Total Parenteral Nutrition (TPN) Equipment and Related Supplies Tracheostomy Supplies Traction/Trapeze Apparatus Wheelchair Accessories Wound Care Supplies Wound Vac and Related Supplies
DYFS/DCF Residential Treatment	Medicaid FFS*	Medicaid FFS*	Medicaid FFS*	NOT COVERED
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (0 through 20 yrs of age)	COVERED	COVERED	COVERED includes physical exams, dental, vision, hearing and lead screening	COVERED EPSDT is limited to well child visits including lead screening and treatment. Immunizations are covered.
Emergency Medical Care	COVERED	COVERED	COVERED (\$10 copay for NJFC C members)	COVERED (\$35 copay for NJFC D members unless referred by PCP or admitted to hospital)
Emergency Medical Transportation (Ambulance)	COVERED	COVERED	COVERED	COVERED
Routine Eye Exams	COVERED	COVERED	COVERED (\$5 copay for NJFC C members)	COVERED including one routine eye exam per year (\$5 copay for NJFC D members, except

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BENEFITS (Subject to policies and procedures)	MEDICAID & NJ FAMILYCARE A	ABD MEMBERS	NJ FAMILYCARE B & C	NJ FAMILYCARE D
				newborns covered under FFS)
Family Planning Basic Services (Self Referral Reproduction Health (Procedures/Devices)	COVERED Member may Self Refer** to participating OB/GYN. Medicaid FFS when furnished by a non-participating doctor	COVERED Member may Self Refer** to participating OB/GYN. Medicaid FFS when furnished by a non-participating doctor	COVERED Member may Self Refer** to participating OB/GYN. Medicaid FFS when furnished by a non-participating doctor	COVERED Member may Self Refer** to participating OB/GYN Family Planning Providers. Services are not available from non-participating doctors with the exception of certain NJ FamilyCare D members. Call Member Services to find out if you qualify at 1-888-464-4365, Monday to Friday, 8 am to 6 pm. TTY users call 1-800-852-7897.
Hearing Exams/Audiology	COVERED	COVERED	COVERED	COVERED (under the age of 16)
Hearing Aids and Batteries	COVERED	COVERED	COVERED	COVERED ( (under the age of 16)
Hemodialysis	COVERED	COVERED	COVERED	COVERED
HIV/AIDS Testing	COVERED	COVERED	COVERED	COVERED
Home Health Care & Infusion Therapy	COVERED	COVERED	COVERED	COVERED Limited to skilled nursing for a homebound beneficiary and medical social services
Hospice Care	COVERED in the community as well as institutional (non-private residence) settings. Hospice for children under age 21 shall cover both	COVERED in the community as well as institutional (non-private residence) settings. Hospice for children under age 21 shall cover both palliative and curative care.	COVERED in the community as well as institutional (non-private residence) settings. Hospice for children under age 21 shall cover both palliative and curative care.	COVERED Hospice care for children under age 19 must cover both palliative and curative care.

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BENEFITS (Subject to policies and procedures)	MEDICAID & NJ FAMILYCARE A	ABD MEMBERS	NJ FAMILYCARE B & C	NJ FAMILYCARE D
	palliative and curative care.			
Immunizations (may be provided in the home for homebound members)	COVERED	COVERED	COVERED	COVERED
Infertility Testing & Services	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED
Inpatient Hospitalization (acute care, rehabilitation and special hospitals)	COVERED	COVERED	COVERED	COVERED
Lab Tests and X-Rays (Diagnostic and therapeutic)	COVERED	COVERED	COVERED	COVERED (\$5 copay for each visit that is not part of an office visit.)
Mammograms (Screening)	COVERED Member may Self Refer**. Baseline for women 35-39 and annual for women 40+	COVERED Member may Self Refer**. Baseline for women 35-39 and annual for women 40+	COVERED Member may Self Refer**. Baseline for women 35-39 and annual for women 40+	COVERED Member may Self Refer**. Baseline for women 35-39 and annual for women 40+
Medical Day Care	COVERED	COVERED	NOT COVERED	NOT COVERED
Medical Supplies	COVERED	COVERED	COVERED	NOT COVERED (except diabetic supplies)

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BENEFITS (Subject to policies and procedures)	MEDICAID & NJ FAMILYCARE A	ABD MEMBERS	NJ FAMILYCARE B & C	NJ FAMILYCARE D
Mental Health/Substance Abuse	<p>COVERED Only for members enrolled in the Division of Developmental Disabilities(DDD)</p> <p>COVERED by Medicaid fee-for-service program for all other members.</p>	<p>COVERED Only for members enrolled in the Division of Developmental Disabilities(DDD)</p> <p>COVERED by Medicaid fee-for-service program for all other members.</p>	<p>COVERED Only for members enrolled in the Division of Developmental Disabilities(DDD)</p> <p>COVERED by Medicaid fee-for-service program for all other members.</p>	<p>COVERED Only for members enrolled in the Division of Developmental Disabilities(DDD)</p> <p>Inpatient hospital services for mental health, including psychiatric hospitals, limited to 35 days per year, covered under Medicaid FFS*. There is no limit to the number of days for CHIP beneficiaries under the age of 19.</p> <p>COVERED by Medicaid fee-for-service program for all other members.</p>
Methadone & Methadone Maintenance	Methadone maintenance for substance abuse treatment is covered by Medicaid FFS*.	Methadone maintenance for substance abuse treatment is covered by Medicaid FFS*	Methadone maintenance for substance abuse treatment is covered by Medicaid FFS*.	Methadone for substance abuse is limited to detox only and is covered by Medicaid FFS*. There is no service limit for CHIP beneficiaries under the age of 19.
Nursing Facility Care (LTC)	COVERED limited to the first 30 days of admission except for rehab admissions.	COVERED limited to the first 30 days of admission except for rehab admissions.	NOT COVERED except for rehabilitation services.	NOT COVERED
Optical Appliances	COVERED	COVERED	COVERED	COVERED Limited to one pair of glasses or contact lenses per 24 month period or as medically necessary.

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BENEFITS (Subject to policies and procedures)	MEDICAID & NJ FAMILYCARE A	ABD MEMBERS	NJ FAMILYCARE B & C	NJ FAMILYCARE D
Organ Transplant	COVERED	COVERED	COVERED	COVERED
Organ Transplant Evaluation	with Prior Authorization	with Prior Authorization	with Prior Authorization	with Prior Authorization
Organ Transplants (Includes donor and recipient costs unless individuals were already placed on a transplant list while in Medicaid FFS or managed care prior to initial enrollment in Healthfirst NJ. Includes donor and recipient inpatient hospital costs for members who are placed on a transplant list or become eligible for a transplant while enrolled in managed care prior to disenrollment to FFS within 2 months of transplant)	COVERED	COVERED	COVERED	COVERED
Orthodontia	COVERED Orthodontic services are only to be provided to children in cases where medical necessity can be proven. Orthodontic treatment will refer to limited, interceptive, and comprehensive	COVERED Orthodontic services are only to be provided to children in cases where medical necessity can be proven. Orthodontic treatment will refer to limited, interceptive, and comprehensive orthodontic treatment as well as all other	COVERED Orthodontic services are only to be provided to children in cases where medical necessity can be proven. Orthodontic treatment will refer to limited, interceptive, and comprehensive orthodontic treatment as well as all other	COVERED Orthodontic services are only to be provided to children in cases where medical necessity can be proven. Orthodontic treatment will refer to limited, interceptive, and comprehensive orthodontic treatment as well as all other ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met.

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	orthodontic treatment as well as all other ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met.	ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met.	ancillary orthodontic services, with these services being considered only when the medical criteria for exemptions as noted above have been met.	
Orthotic Devices	COVERED	COVERED	COVERED	NOT COVERED
Outpatient Hospital, Outpatient Surgery, Same Day Surgery, Ambulatory Surgical Center	COVERED	COVERED	COVERED	COVERED Excludes mental health visits
Pain Management Services	COVERED	COVERED	COVERED	COVERED
Pap Smears and Pelvic Exams	COVERED	COVERED	COVERED	COVERED
Parenting/Child Birth Education	COVERED	COVERED	COVERED	COVERED
Personal Care Assistance Services (in residence)	COVERED Limit up to 40 hours per week	COVERED Limit up to 40 hours per week	NOT COVERED	NOT COVERED

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BENEFITS (Subject to policies and procedures)	MEDICAID & NJ FAMILYCARE A	ABD MEMBERS	NJ FAMILYCARE B & C	NJ FAMILYCARE D
Podiatry Services	COVERED	COVERED	COVERED (\$5 copay per visit for NJFC C members)	COVERED Excludes routine hygienic care of the feet, including the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet in the absence of a pathological condition. (\$5 copay per visit)
Prescription Drugs	COVERED	<u>ABD</u> Medicaid only – Prescription drug coverage through HFNJ will begin July 1, 2011.  ABD Medicaid/Medicare - Prescription drug coverage through HFNJ expected to begin in Fall 2011. Until then, remains in FFS.	COVERED NJFC C members pay \$1 copay for generic; \$5 copay for brand.	COVERED No OTC drug coverage. NJFC D members pay \$5 copay for generic or brand, \$10 for over 34 day supply.
Post-Acute Care	COVERED  Up to 30 days at Medicaid-participating acute-care hospital or nursing facility	COVERED  Up to 30 days at Medicaid-participating acute-care hospital or nursing facility.	COVERED  Up to 30 days at Medicaid-participating acute-care hospital or nursing facility	COVERED  Up to 30 days at Medicaid- participating acute-care hospital or nursing facility

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Preventive Health Care & Counseling/ Health Promotion	COVERED	COVERED	COVERED	COVERED
Primary Care Provider	COVERED	COVERED	COVERED (NJFC C members pay \$5 copay/visit except for well-child visits, lead screening & treatment, immunizations, prenatal care, pap smears)	COVERED (NJFC D members pay \$5 copay/visit when provided during normal office hours except for well-child visits, lead screening & treatment, immunizations, prenatal care, pap smears. \$5 copay only applies to the first prenatal visit. When provided during non-office hours and for home visits, copay is \$10.)
Private Duty or Nursing Care	COVERED If related to EPSDT screening	COVERED If related to EPSDT screening	COVERED If related to EPSDT screening	NOT COVERED Unless authorized by Healthfirst NJ
Prostate Cancer Screening Exams (recommended for males age 50 and above)	COVERED	COVERED	COVERED	COVERED
Prosthetics	COVERED	COVERED	COVERED	COVERED Prosthetics limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect. Repair and replacement services are covered when due to congenital growth.
Radiation/Chemotherapy/	COVERED	COVERED	COVERED	COVERED

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Hemodialysis				
Radiology Scans (MRI, MRA, PET)	COVERED	COVERED	COVERED	COVERED (NJFC D members pay \$5 copay when not part of an office visit.)
Second Medical/ Surgical Opinions (Second Opinions)	COVERED	COVERED	COVERED	COVERED
Rehabilitation (Outpatient Occupational Therapy/ Physical Therapy/ Speech Therapy, Inpatient Rehab Facility)	COVERED	COVERED	COVERED  Outpatient Rehab limited to 60 days per therapy per incident per calendar year.	COVERED  Outpatient Rehab limited to 60 days per therapy per incident per calendar year. Speech therapy for treatment of delays in speech development, unless the delay results from disease, injury, or congenital defects, is NOT covered.  (\$5 copay each visit for outpatient rehab)
Sex Abuse Examinations	Medicaid FFS*	Medicaid FFS*	Medicaid FFS*	Medicaid FFS*
Sleep Apnea Studies	COVERED	COVERED	COVERED	COVERED
Sleep Therapy	COVERED	COVERED	COVERED	NOT COVERED
Smoking Cessation	COVERED	COVERED	COVERED	COVERED
Specialty Physician Services	COVERED	COVERED	COVERED	COVERED (\$5 copay during office hours; \$10 copay during non-office hours or home visit)
Speech Tests	COVERED	COVERED	COVERED	COVERED
Thermograms & Thermography	COVERED	COVERED	COVERED	NOT COVERED
Transportation – Emergency only- Ambulance	COVERED	COVERED	COVERED	COVERED
Transportation – Non- Emergency – Ambulance,	Medicaid FFS*	Medicaid FFS*	Medicaid FFS*	NOT COVERED

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MICU, Invalid Coach				
Transportation – Lower Mode	Medicaid FFS*	Medicaid FFS*	NOT COVERED	NOT COVERED
Urgent Care	COVERED	COVERED	COVERED	COVERED for emergencies only (Triage and medical screenings must be covered in all cases) \$35 copay; no copay required if member is referred by PCP for services that should have been performed in PCP's office, or if member is admitted to hospital.

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## Benefits and Services Excluded from Coverage

<b>Services Not Covered for NJ Medicaid or FamilyCare A, B, C Enrollees</b>	<b>Services Not Covered for NJ FamilyCare D Enrollees</b>
<ul style="list-style-type: none"> <li>• Services not medically necessary</li> <li>• Cosmetic surgery, except when medically necessary and with prior approval</li> <li>• Experimental organ transplants and investigational services</li> <li>• Infertility treatment services</li> <li>• Rest cures, personal comfort, convenience items and custodial care</li> <li>• Respite Care</li> <li>• Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey and regulations issued pursuant thereto</li> <li>• All claims arising directly from services provided by or in institutions owned or operated by the federal government such as Veterans Administration hospitals</li> <li>• Services provided in an inpatient psychiatric institution, that is not an acute care hospital, to individuals under 65 years of age and over 21 years of age.</li> <li>• Services provided to all persons without charge. Services and items provided without charge through programs of other public or voluntary agencies (for example, New Jersey Department of Health and Senior Services, New Jersey Heart Association, First Aid Rescue Squad and so forth) shall be utilized to the fullest extent possible.</li> <li>• Services or items furnished for any sickness or injury occurring while the covered person is on active duty in the military.</li> <li>• Services provided outside the United States and territories.</li> <li>• Services or items furnished for any condition or accidental injury arising out of and in the course of employment for which any benefits are available under</li> </ul>	<ul style="list-style-type: none"> <li>• Non-medically necessary services</li> <li>• Intermediate Care Facilities/Intellectual Disability</li> <li>• Private duty nursing unless authorized by the contractor</li> <li>• Personal Care Assistant Services</li> <li>• Medical Day Care Services</li> <li>• Chiropractic Services</li> <li>• Dental service except for children under age 19</li> <li>• Orthotic devices</li> <li>• Residential treatment center psychiatric programs</li> <li>• Religious non-medical institutions care and services</li> <li>• EPSDT except for well-child care including immunizations and lead screening and treatments</li> <li>• Transportation Services including non-emergency ambulance, invalid coach and lower mode transportation</li> <li>• Hearing Aid Services except for children under 16 years</li> <li>• Blood and Blood Plasma, except administration of blood, processing of blood, processing fees and fees related to autologous blood donations are covered</li> <li>• Cosmetic Services</li> <li>• Custodial Care</li> <li>• Special Remedial and Educational Services</li> <li>• Experimental and Investigational Services</li> <li>• Medical Supplies, except diabetic supplies</li> <li>• Infertility Services</li> </ul>

the provisions of any workers' compensation law, temporary disability benefits law, occupational disease law, or similar legislation, whether or not the Medicaid beneficiary claims or receives benefits hereunder and whether or not any recovery is obtained from a third-party for resulting damages.

- That part of any benefit which is covered or payable under any health, accident, or other insurance policy (including any benefits payable under the New Jersey no-fault automobile insurance laws), any other private or governmental health benefit system, or through any similar third-party liability, which also includes the provision of the Unsatisfied Claim and Judgment Fund.
- Any service or items furnished for which the provider does not normally charge.
- Services furnished by an immediate relative or member of the Medicaid beneficiary's household.
- Services billed for which corresponding health care records do not adequately and legibly reflect the requirements of the procedure code utilized by the bill provider.
- Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or beneficiary income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the State of New Jersey.

- Rehabilitative Services for Substance Abuse
- Weight reduction programs or dietary supplements, except surgical operations, procedures or treatment of obesity when approved by the contractor
- Acupuncture and acupuncture therapy, except when performed as a form of anesthesia in connection with covered surgery
- Temporomandibular joint disorder treatment, including treatment performed by prosthesis placed directly in the teeth
- Recreational Therapy
- Sleep Therapy
- Court-ordered services
- Thermograms and thermography
- Biofeedback
- Radial keratotomy
- Respite Care
- Nursing facility services
- Audiologist Services, except for children under 16 years