GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT
BUREAU OF HEALTH CARE FINANCING ADMINISTRATION

Public Health Benefits Plans

Benefits and Limitations

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Abortion	**Covered w/ PA** Life-endangering physical condition caused or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed.	**Not covered**	**Not covered**
Acupuncture	**Not covered**	**Covered** 30 visits per fiscal year.	**Covered** 10 visits at $50 per visit, per fiscal year.
Acute Inpatient Services	**Covered** Up to 60 days inpatient hospitalization per confinement.	**Covered** Up to 60 days inpatient hospitalization per confinement.	**Covered** Up to 60 days inpatient hospitalization per confinement.
	Covered w/ PA After the first 60 days that includes weekends.	**Covered w/ PA** After the first 60 days that includes weekends.	**Covered w/ PA** After the first 60 days that includes weekends.
Allergy Testing/Treatment	**Not covered**	**Covered w/ PA** Up to $500 per year.	**Not covered**
		Covered w/ PA Testing/Treatment in excess of $500 per year.	
Ambulance and Medical Transportation	**Covered** Emergency ambulance service. Non-emergency, medically necessary stretcher, wheelchair, bed-confined medical transportation service.	**Covered** Emergency ambulance service. Non-emergency, medically necessary stretcher, wheelchair, bed-confined medical transportation service.	**Covered** Inpatient ambulance service.
Ambulatory Surgical Center	**Covered**	**Covered w/ PA and physician's referral**	**Covered**
Audiological Examination	**Covered w/ PA and physician's referral**	**Covered w/ physician's referral**	**Covered w/ PA and physician's referral** Up to $100 per visit.
Birthing Center Services	**Covered**	**Covered**	**Covered**

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Blood and Blood Products	**Covered**	**Covered**	**Covered** Up to $50,000 per fiscal year. This limitation does not apply to any person with hemophilia or any hemophilia-related condition requiring the administration of blood and blood products.
Bone Marrow Transplant	**Covered** Inpatient (in accordance with Medicare standards under NCD 110.23, TN 12627, L39396 and A59175).	**Covered** Inpatient (in accordance with Medicare standards under NCD 110.23, TN 12627, L39396 and A59175).	**Not covered**
Breast Reconstructive Surgery	**Not covered**	**Covered w/ PA** Relating to medically necessary mastectomy.	**Covered** Relating to medically necessary mastectomy.
Cataract Surgery	**Covered** Includes conventional intraocular lens	**Covered** Outpatient only, includes conventional intraocular lens.	**Covered** Includes conventional intraocular lens.
Chemical Dependency	**Covered** 20 and below covered without limitation. 21 and older covered as outpatient basis for up to 20 sessions.	**Covered** Outpatient psychiatric and psychological services to include counseling and medications. Hospital and Inpatient: Acute admissions for chemical dependency.	**Covered** Outpatient psychiatric and psychological services to include counseling and medications. Maximum $10,000 per fiscal year.
Chemotherapy	**Covered**	**Covered**	**Covered**
Chiropractic	**Not covered**	**Covered** 30 visits/fiscal year.	**Covered** 10 visits at $25 per visit per fiscal year.
Circumcision	**Covered w/ PA** Medically necessary circumcision.	**Not covered**	**Covered w/ PA** Medically necessary circumcision.
Congenital Anomaly Diseases	**Covered**	**Covered**	**Covered**
Dental Services	**Covered**	**Covered** Under 21 years only.	**Covered‡** 17 years and over only. ‡20% coinsurance.

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Diagnostic Testing	**Covered**	**Covered** Includes diagnostic radiology and laboratory services.	**Covered**
Durable Medical Equipment (DME)/ Supplies (medical equipment/machine limited to every 5 years)	**Covered w/ physician referral only** Nebulizer, glucometer machine, crutches and walker.	**Covered w/ physician referral only** Crutches and walker.	**Covered w/ physician referral only** Crutches and walker.
	Covered w/ PA Bed, c-pap/bi-pap machine, oxygen system, wheelchair and medical supplies.	**Covered w/ PA** Bed, c-pap machine, oxygen system, wheelchair and medical supplies.	**Covered w/ PA** Wheelchair, hospital bed and medical supplies only.
		Not covered Bi-pap machine, nebulizer and glucometer machine.	**Not covered** C-pap/bi-pap machine, nebulizer and glucometer machine.
Elective Surgery	**Covered** Medically necessary elective surgery.	**Covered** Non-emergency outpatient surgery.	**Covered** Medically necessary outpatient elective surgery.
	Covered w/ PA Medically necessary elective surgery with one or more day admission prior to surgery.		**Covered w/ PA** Medically necessary elective surgery with one or more day admission prior to surgery.
Emergency Care	**Covered**	**Covered** On/Off-Island emergency facility, physician services, laboratory, radiology services. Ambulance ground transportation only. Emergency air transportation at a participating provider.	**Covered** On-Island emergency facility, physician services, laboratory, radiology services. Inpatient ambulance ground transportation only.
Emergency Room Services	**Covered** Emergency only.	**Covered** Emergency only.	**Covered‡** Emergency only.
			‡$5 co-payment.
End Stage Renal Disease/ Hemodialysis	**Covered**	**Covered**	**Covered**

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Fitness	**Not covered**	**Covered w/ PA and physician's referral** Gym memberships at a participating provider. At least 5 visits a month required for monthly continuation coverage, unless w/ medical justification.	**Not covered**
Hearing Aid	**Covered w/ PA** Limited to every three (3) years, standard only.	**Covered w/ PA** Up to $500 every 3 years, standard only.	**Covered w/ PA** Up to $500 per hearing aid, standard only.
Home Health Services	**Covered w/ PA and Home Care Referral** Nursing Services (LPN/RN) Home Health Aide Services	**Covered w/ Home Care Referral** Nursing Services (LPN/RN)	**Covered w/ Home Care Referral** Up to 100 days per fiscal year.
Hospice Care	**Covered w/ PA** 90-day periods (up to 2), followed by an unlimited number of 60-day periods.	**Covered w/ PA** Up to 180 days.	**Covered w/ PA** Up to 180 days.
Immunizations/ Vaccinations	**Covered** CDC Advisory Committee on Immunization Practices Guideline.	**Covered** CDC Advisory Committee on Immunization Practices Guideline.	**Covered** CDC Advisory Committee on Immunization Practices Guideline.
Inhalation Therapy	**Covered**	**Covered**	**Covered**
Laboratory	**Covered**	**Covered*** *Diagnostic Laboratory: $5.00 co-payment for visit that agency pays $50 and over.	**Covered**
Maternity Care	**Covered**	**Covered** Labor and delivery	**Covered**

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Mental Health Services	**Covered** Mental Disorders and Psychological Services • For individuals under 21 years, without limitation. • For individuals 21 years and older, on an outpatient basis up to 20 sessions. Service Plan Development Individual Therapy Group Therapy Family Counseling Medication Management Rehab Care Coordination	**Covered** Outpatient psychiatric and psychological services to include counseling and medications. Hospital and Inpatient: Acute admissions for mental health or chemical dependency.	**Covered** Up to 30 days inpatient hospitalization per illness.
Nuclear Medicine	**Covered**	**Covered w/ PA*** *$5.00 co-payment for visit that agency pays $50 and over.	**Covered**
Occupational/ Physical Therapy	**Covered w/ PA** Occupational and Physical Therapy: • Inpatient and outpatient, without limitation. • Hospice service, for purposes of symptom control or to enable patient to maintain activities of daily living and basic functional skills.	**Covered w/ PA and Physician Referral** • Includes the maintenance, acquisition and restoration of skills as inpatient and outpatient services only. Limited to 20 visits per fiscal year. • Visits in excess of 20 per fiscal year.	**Covered w/ PA** Up to 20 visits per fiscal year. **Covered w/ recertification‡** Continuing treatment in excess of 20 visits. ‡Over 20 visits per fiscal year is subject to 50% coinsurance.
Off-Island Medical Care	**Covered w/ approved off-island referral/treatment and PA.** Medically necessary inpatient or outpatient services that are not available on Guam.	**Covered w/ approved off-island referral/treatment and PA.** Medically necessary inpatient hospital services that are not available on Guam.	**Covered w/ approved off-island referral/treatment and PA.** Medically necessary inpatient or outpatient services that are not available on Guam. Up to $175,000 per fiscal year, including airfare/ travel and escort fees.

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Off-Island Medical Transportation	**Covered w/ approved off-island referral and PA** Round trip economy fare air transportation for covered inpatient/outpatient services at an off-island hospital provider including: • 1 parent/guardian for beneficiary under 18 years. • 1 medical escort for beneficiary requiring assistance due to visual, orthopedic or mental impairments.	**Covered w/ approved off-island referral and PA** Round trip air transportation for covered Inpatient Services at an off-island hospital provider. For open heart surgery, oncology surgery, aneurysmectomy, pneumonectomy, intracranial surgery, acute leukemia, gamma knife or if the level of care required is NICU Level III, or if the expected cost of the services exceeds $25,000. the following may be authorized for round trip air transportation: • One companion. • One medical escort when medically necessary. • Additional escort when medically necessary and unable to self-care.	**Covered w/ approved off-island referral and PA** Round trip air transportation including: • 1 parent/guardian for beneficiary under 18 years. • 1 medical escort if medically necessary.
Orthopedic Services/Conditions	**Covered** Medically necessary orthopedic devices, certain to save life or significantly alter an adverse prognosis to include internal and external prosthesis (including lower limb prostheses), injections and related devices.	**Covered** Includes internal and external prosthesis (including lower limb prostheses). Orthopedic injections not included.	**Covered‡** Includes internal and external prosthesis. Up to $50,000 per fiscal year on related services and treatment/ device (prosthesis). ‡10% coinsurance.
Personal Care Services	**Not covered**	**Not covered**	**Not covered**
Physical Examination (PE)/EPSDT	**Covered w/ PA** • Under 21 years, EPSDT periodicity schedule, including oral and vision care. • 21 years and older, every 12 months, Preventive Care Services (USPTF guideline).	**Covered w/ PA** • Under 21 years, EPSDT periodicity schedule, including oral and vision care. • 21 years and older, every 12 months, Preventive Care Services (USPTF guideline).	**Covered w/ PA‡** Every 12 months, Preventative Care Services (USPTF guideline). ‡$5 co-payment for only PE visits.

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Physical Examination: Birth Control Consultation	**Covered w/ Physical Examination PA** Women 16 years and over.	**Covered w/ Physical Examination PA** Women 16 years and over.	**Covered w/ Physical Examination PA** Women 16 years and over.
Physical Examination: Cancer Screenings	**Covered w/ PA** Screening Mammography • 35-39 years: every year. • 40-49 years: every 2 years. • 50 years and over: every year.	**Covered w/ PA** Screening Mammography • 35-39 years: every year. • 40-49 years: every 2 years. • 50 years and over: every year.	**Covered w/ PA** Screening Mammography‡ • 35-39 years: every year. • 40-49 years: every 2 years. • 50 years and over: every year.
	Covered w/ PA Pap Smear • 16 years and over: every year, or every 3 years after 3 consecutive satisfactory normal/ negative pap smear.	**Covered w/ PA** Pap Smear • 16 years and over: every year, or every 3 years after 3 consecutive satisfactory normal/ negative pap smear.	**Covered w/ PA** Pap Smear‡ • 16 years and over: every year, or every 3 years after 3 consecutive satisfactory normal/ negative pap smear.
	Covered w/ PA Pelvic Examination • 16 years and over: every 36 months.	**Covered w/ PA** Pelvic Examination • 16 years and over: every 36 months.	**Covered w/ PA** Pelvic Examination‡ • 16 years and over: every 36 months.
	Covered w/ PA Flexible Sigmoidscopy • Every 48 months for 50 years old and over, or 120 months after a previous screening colonoscopy for those not at high risk.	**Covered w/ PA** Flexible Sigmoidscopy • Every 48 months for 50 years old and over, or 120 months after a previous screening colonoscopy for those not at high risk.	**Covered w/ PA** Flexible Sigmoidscopy‡ • Every 48 months for 50 years old and over, or 120 months after a previous screening colonoscopy for those not at high risk. ‡$5 co-payment.
Physical Examination: Cancer Screenings (continued)	**Covered w/ PA** Colonoscopy • Every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidscopy.	**Covered w/ PA** Colonoscopy • Every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidscopy.	**Covered w/ PA** Colonoscopy‡ • Every 120 months (high risk every 24 months), or 48 months after a previous flexible sigmoidscopy.
	Covered w/ PA Prostate Surface Antigen • 50 years and over: every year.	**Covered w/ PA** Prostate Surface Antigen • 50 years and over: every year.	**Covered w/ PA** Prostate Surface Antigen‡ • 50 years and over: every year. ‡$5 co-payment.
Physician Services	**Covered**	**Covered**	**Covered**

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Podiatry Services	**Covered** Medically necessary podiatry services that are reasonable and necessary for the diagnosis and/or treatment of illness or injury or to improve functioning of a malformed body member. Excludes routine foot care, evaluation or treatment or subluxation of the feet, evaluation and treatment of flattened arches.	**~~Not~~ covered**	**Covered** Medically necessary podiatry services.
Prenatal and Postpartum Care	**Covered**	**Covered**	**Covered**
Prescribed Drugs	**Covered** Limited to Drug Formulary and 30-day supply at one time.	**Covered*** Limited to Drug Formulary and 30-day supply at one time.	**Covered‡** Limited to Drug Formulary and 30-day supply at one time.
	Covered w/ PA Non-formulary or brand name drug.	**Covered w/ PA*** Non-formulary or brand name drug.	**Covered w/ PA‡** Non-formulary or brand name drug.
		*$2.50 copay per prescription drug that agency pays $25 and over.	‡$2.50 copay per prescription.
Prosthetic Appliances	**Covered** Medically necessary prosthetic devices, certain to save life or significantly alter an adverse prognosis to include pacemakers, heart valves, stents and related devices. Lower limb prostheses (in accordance with Medicare standards under L33787 and A52496).	**Covered** Includes Pacemakers, heart valves and stents. Orthopedic: Includes Internal and External Prosthesis. Lower limb prostheses (in accordance with Medicare standards under L33787 and A52496).	**Covered‡** Orthopedic: Includes Internal and External Prosthesis. Lower limb prostheses (in accordance with Medicare standards under L33787 and A52496). Up to $50,000 per fiscal year. on related services and treatment/device (prosthesis).
			‡10% coinsurance
Radiation Therapy	**Covered**	**Covered**	**Covered‡**
			‡10% coinsurance.

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ⁑Cost sharing required.
Radiology	**Covered w/ PA** CT scan, MRA and MRI only.	**Covered w/ PA*** CT, Scan, MRA, MRI and other type of non-invasive diagnostic imaging. *Diagnostic Radiology: $5.00 co-payment for visit that agency pays $50 and over.	**Covered w/ PA⁑** CT scan, MRA and MRI only ⁑10% coinsurance.
Skilled Nursing Facility	**Covered** Up to 180 days per fiscal year.	**Covered** Up to 60 days per fiscal year.	**Covered** Up to 180 days per fiscal year.
Sleep Apnea	**Covered w/ PA** Sleep apnea	**Covered w/ PA** Diagnostic and therapeutic procedures.	**Covered w/ PA** Sleep apnea
Tobacco Cessation	**Covered** Tobacco Cessation only: Counseling and medication for two (2) cessation attempts per year. Each cessation attempt is at least four (4) sessions of at least 30 minutes face-to-face each.	**Not covered**	**Not covered**
Tobacco Cessation (continued)	**Covered w/ PA** Extended treatment duration past 90 days (24 weeks for varenieline) and number of cessation attempts exceeding 2 per year.	**Not covered**	**Not covered**
Transcranial Magnetic Stimulation (TMS)	**Covered w/ PA and prescribed by a physician** Treatment of major depression. Only when determined medically necessary and adhering to established standards under Medicaid/MIP policy. • Initial course of treatment (up to 20 sessions). • Each additional course of treatment (20 sessions).	**Covered w/ PA and prescribed by a physician** Treatment of major depression. Only when determined medically necessary and adhering to established standards under Medicaid/MIP policy. • Initial course of treatment (up to 20 sessions). • Each additional course of treatment (20 sessions).	**Covered w/ PA and prescribed by a physician** Treatment of major depression. Only when determined medically necessary and adhering to established standards under Medicaid/MIP policy. • Initial course of treatment (up to 20 sessions). • Each additional course of treatment (20 sessions).

Service	Medicaid State Plan	Alternative Benefit Plan *Cost sharing required over standard income limit.	Medically Indigent Program ‡Cost sharing required.
Vision	**Covered w/ PA** Refractive eye exam Once every 2 years or when necessary by screening.	**Covered w/ PA** Refractive eye exam Individuals under 21 years of age. Limited to every 2 years.	**Covered w/ PA** Refractive eye exam Up to $50 every year.
	Covered w/ PA Eye glasses • Corrective Lenses: Up to $150 every 2 years. • Bi-focal Lenses: Up to $200 every 2 years.	**Covered w/ PA** Eye glasses Individuals under 21 years of age. Limited to every 2 years.	**Covered w/ PA** Eye glasses • Corrective Lenses: Up to $100 every 2 years. • Bi-focal Lenses: Up to $100 every 2 years.
Voluntary Sterilization Services	**Covered w/ PA** 21 years and over only. Consent to Sterilization Form is valid after 30 days and not to exceed 180 days from the signature date of the patient.	**Covered w/ PA** 21 years and over only. Tubal Ligation and Vasectomy: Outpatient only. Consent to Sterilization Form is valid after 30 days and not to exceed 180 days from the signature date of the patient.	**Covered w/ PA** 21 years and over only. Consent to Sterilization Form is valid after 30 days and not to exceed 180 days from the signature date of the patient.
Well Child Care/EPSDT	**Covered** Individuals under 21 years of age. EPSDT periodicity schedule.	**Covered** Individuals under 21 years of age. EPSDT periodicity schedule.	**Covered** Limited to 6 visits per year. up to age 2, excluding visits for immunization.
Wellness	**Not covered**	**Covered w/ PA** Counseling and monitoring of patient's condition under programs such as: • A Mini-Newstart Program • Gestational Diabetes Program • Breathe-Free Stop Smoking Program. Up to $200 per year.	**Not covered**
Alternative Medically Indigent Program Plans: 92-MIPLB: Lytico/ Bodig 93-MIPIDD: Insulin Dependent Diabetes 94-MIPTB: Tuberculosis 95-MIPMS: Medicaid Supplemental (St. Dominic's/ GMHA ICF)/ GCAT) 97-MIPRF: End Stage Renal Disease 99-MIPLPS: Leprosy			