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**State/Territory Name: Utah**

**State Plan Amendments (SPA) #: UT-19-0021**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, MD 21244-1850



Children and Adults Health Programs Group

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NOV 07 2019

Jeff Nelson  
CHIP Director  
Division of Medicaid and Health Financing  
P.O. Box 143101  
Salt Lake City, UT 84114-3101

Dear Mr. Nelson:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), UT-19-0021, submitted on June 26, 2019, with additional information submitted on November 7, 2019, has been approved. UT-19-0021 demonstrates compliance with the CHIP managed care regulations and removes the 25-day limitation on residential treatment per plan year and the co-payment for an outpatient facility or office visit for mental health services. In addition, this SPA excludes Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorder from CHIP coverage and updates the dental delivery contractor. These benefit changes are effective as of July 1, 2019.

SPA UT-19-0021 demonstrates compliance with the CHIP managed care regulations at 42 CFR 457, Subpart L, for utilization of a managed care delivery system with an effective date of July 1, 2018. Sections 2101(a), 2103(f)(3), 2107(b), and 2107(e) of the Social Security Act, as implemented through regulations at 42 CFR 457 Subpart L, describe the application of managed care requirements to CHIP. Utah has provided the necessary assurances indicating that the state complies with the managed care requirements in the delivery of CHIP services and benefits covered under the state's separate child health plan as of July 1, 2018.

This SPA approval does not substitute for CMS review of any contracts between the state and managed care entities that serve the state's CHIP populations. All managed care contracts for CHIP populations in effect as of the state fiscal year beginning on or after July 1, 2018 must comply with the CHIP managed care regulations and be submitted for CMS review.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
7500 Security Boulevard, Mail Stop: S2-01-16  
Baltimore, MD 21244-1850  
Telephone: (410) 786-3413  
E-mail: [Joyce.Jordan@cms.hhs.gov](mailto:Joyce.Jordan@cms.hhs.gov)

Official communications regarding program matters should be sent simultaneously to Ms. Jordan and to Richard Allen, Director, Division of Medicaid Field Operations West. Mr. Allen's address is:

Centers for Medicare & Medicaid Services  
1961 Stout Street  
Room 08-148  
Denver, Colorado 80294

If you have additional questions, please contact Amy Lutzky, Director, Division of State Coverage Programs at (410) 786-0721.

We look forward to continuing to work with you and your staff.

Sincerely,

/signed Anne Marie Costello/

Anne Marie Costello  
Director

cc:

Mr. Richard Allen, Director, Division of Medicaid Field Operations West

**TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S  
HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: The State of Utah

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

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(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Nathan Checketts	Position/Title: Director, Medicaid and Health Financing
Name: Jeff Nelson	Position/Title: CHIP Director
Name: Jennifer Wisner	Position/Title: CHIP Program Manager

**\*Disclosure.** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Introduction:** Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)

- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

**Federal Requirements for Submission and Review of a Proposed SPA.** (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a “clean” copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and

under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)

5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State’s use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also



have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)

8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and

2107(e); (42 CFR 457, subpart I)

**12. Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

**Program Options.** As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

#### **Medicaid Expansion- CHIP SPA Requirements**

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)

- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

### **Medicaid Expansion- Medicaid SPA Requirements**

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the descriptions of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections) indicating State
- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to

cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Amy Lutzky  
Centers for Medicare & Medicaid Services  
7500 Security Blvd  
Baltimore, Maryland 21244  
Attn: Children and Adults Health Programs Group  
Center for Medicaid, CHIP and Survey & Certification  
Mail Stop - S2-01-16

SPA# 17, Purpose of SPA: Rebenchmark CHIP dental benefits

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

SPA# 18, Purpose of SPA: FQHC Payment Methodology

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

SPA# 19-0021, Purpose of SPA: Update CHIP benefits

Sections 6 and 8

Proposed effective date: July 1, 2019

Proposed implementation date: July 1, 2019

Section 3:

Proposed effective date: July 1, 2018

Proposed implementation date: July 1, 2018

***Superseding Pages of MAGI CHIP State Plan Material***

***State: Utah***

<b>Transmittal Number</b>	<b>SPA Group</b>	<b>PDF #</b>	<b>Description</b>	<b>Superseded Plan Section(s)</b>
<b>UT-13-0001</b>	MAGI Eligibility & Methods	CS7	Eligibility – Targeted Low Income Children	Supersedes the current sections Geographic Area 4.1.1; Age 4.1.2; and Income 4.1.3

<b>Transmittal Number</b>	<b>SPA Group</b>	<b>PDF #</b>	<b>Description</b>	<b>Superseded Plan Section(s)</b>
Approval Date: 12/19/13 Effective/Implementation Date: January 1, 2014		CS15	MAGI-Based Income Methodologies	Incorporate within a separate subsection under section 4.3
<b>UT-13-0005</b>  Approval Date: 10/08/14 Effective/Implementation Date: January 1, 2014	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes the current Medicaid expansion section 4.0
<b>UT-13-0002</b>  Approval Date: 11/01/13 Effective/Implementation Date: January 1, 2014	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	Incorporate within a separate subsection under section 4.1
<b>UT-13-0003</b>  Approval Date: 11/01/13 Effective/Implementation Date: October 1, 2013	Eligibility Processing	CS24	Eligibility Process	Supersedes the current sections 4.3 and 4.4
<b>UT-13-0004</b>  Approval Date: 12/19/13 Effective/Implementation Date: January 1, 2014	Non-Financial Eligibility	CS17  CS18  CS19	Non-Financial Eligibility – Residency  Non-Financial Eligibility – Citizenship	Supersedes the current section 4.1.5  Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
		CS20	Non-Financial Eligibility – Social Security Number	Supersedes the current section 4.1.9.1
		CS21	Non-Financial Eligibility -Substitution of Coverage	Supersedes the current section 4.4.4
		CS27	Non-Financial Eligibility – Non-Payment of Premiums	Supersedes the current section 8.7
			Continuous Eligibility	Supersedes the current section 4.1.8
<b>UT-16-0001</b> Approval Date: 08/18/16 Effective Date: July 1, 2016	Non-Financial Eligibility	CS18	Non-Financial Eligibility – Citizenship (CHIPRA section 214)	Supersedes the current sections 4.1.0; 4.1-LR; 4.1.1-LR
<b>UT-17-0003</b> Approval Date: 04/27/17 Effective Date: January 1, 2017	MAGI Eligibility & Methods	CS15	MAGI-Based Income Methodologies (Estranged spouses)	Incorporate within a separate subsection under section 4.3

State Plan Amendment 13 was presented at the Utah Indian Health Advisory Board meeting on August 3, 2012. Consultation was not requested.

State Plan Amendment 14 was presented at the Utah Indian Health Advisory Board meeting on 08/08/2014. Consultation was not requested.

State Plan Amendment 15 was presented at the Utah Indian Health Advisory Board meeting on 12/12/2014. Consultation was not requested.

State Plan Amendment 16 was presented at the Utah Indian Health Advisory Board meeting on 10/9/2015. Consultation was not requested.

State Plan Amendment 17 was presented at the Utah Indian Health Advisory Board meeting on 7/8/2016. Consultation was not requested.

State Plan Amendment 18 was presented at the Utah Indian Health Advisory Board meeting on 3/10/2017. Consultation was not requested.

State Plan Amendment 19-0021 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2019. Consultation was not requested.

TN No: Approval Date Effective Date \_\_\_\_\_

6.2.3.  **Physician services** (Section 2110(a)(3))



## Scope of Coverage

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

## Exclusions

1. Acupuncture and acupressure
2. Services obtained for administrative purposes. Such administrative purposes include services obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements. Provider and Facility charges for completing insurance forms, duplication services, interest (except where required by Utah Administration Code R590-192), finance charges, late fees, shipping and handling, missed appointments, and other administrative charges.
3. The following allergy test are not covered: Cytotoxic test, leukocyte histamine release test, mediator release test, passive cutaneous transfer test, provocative conjunctival test, provocative nasal test, rebuck skin window test, rinkel test, subcutaneous provocative food and chemical test, sublingual provocative food and chemical test. The following allergy treatments are not covered: allergoids, autogenous urine immunizations, LEAP therapy, medical devices (filtering air cleaner, electrostatic air

cleaner, air conditioners etc.), neutralization therapy, photo-inactivated extracts, polymerized extracts, oral desensitization/ immunotherapy.

4. General anesthesia in a provider's office.

5. Cognitive or behavioral therapies for the treatment of attention deficit/hyperactivity disorder.

6. Biofeedback/neurofeedback

7. The following cancer therapies are not covered: neutron beam therapy and proton beam therapy.

8. Services or an illness, condition, accident, or injury are not covered if occurred:

a. While the member was a voluntary participant in the commission of a felony

b. While the member was a voluntary participant in disorderly conduct, riot, or other breach of the peace

c. While the member was engaged in any conduct involving the illegal use or misuse of a firearm or other deadly weapon

d. While the member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off-road vehicle, boat, or other motor driven vehicle if the member either had sufficient alcohol in the member's body that a subsequent test shows that the member has either a blood or breath alcohol concentration of .08 grams or greater at the time of the test or had any illegal drug or their illegal substance in the member's body to a degree that it affected the members' ability to drive or operate the vehicle

e. While the member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off road vehicle, boat, or other motor driven vehicle either without a valid driver's permit or license, if required under

the circumstances or without the permission of the owner of the vehicle  
f. As a complication of, or as the result of, or as follow up care for, any illness, condition, accident, or injury that is not covered as the result of this exclusion

9. Generally, claims with a date of service over one year old should be denied by the plan. Exceptions to this general rule should be addressed by the plan's policy and in its procedures.

10. Complementary, alternative and nontraditional services. Such services include acupuncture, homeopathy, homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography

11. All services provided or ordered to treat complications of non-covered services are not covered unless stated otherwise in this document.

12. Custodial care

13. Dry needling procedures

14. Services for which the member has obtained a payment, settlement, judgment, or other recover for future payment intended as compensation

15. Services received by a member incarcerated in a prison, jail, or other correctional facility at the time services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration

16. Experimental and/or investigational services for which one or more of the following apply: it cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use; it is the subject of a current investigational new drug or new device application on file with the FDA; it

is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; it is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); if the predominant opinion among the appropriate experts as expressed in the peer reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role and value of the service.

17. Fitness training, conditioning, exercise equipment, and membership fees to a spa or health club.

18. Except for dietary products as defined by the Health Plan, food supplements and substitutes are not covered.

19. Gene therapy or gene based therapies

20. Services designed to create or establish function that was not previously present

21. The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.

22. When a non-covered service is performed as part of the same operation or process as a covered service, only charges relating to the covered service will be considered. Allowed amounts may be calculated and fairly apportioned to exclude any charges related to the non-covered service.

23. The following pain management services are not covered: prolotherapy, radiofrequency ablation of dorsal root ganglion,

acupuncture, IV pamidronate therapy for the treatment of reflex sympathetic dystrophy

24. Services for pervasive developmental disorder

25. Services provided to a member by a provider who ordinarily resides in the same household as the member

26. Service related to sexual dysfunction

27. Coverage for specific specialty services may be restricted to only those providers who are board certified or have other formal training that is considered necessary to perform those services

28. The following specific services are not covered: anodyne infrared device for any indication; auditory brain implantation; chronic intermittent insulin IV therapy/metabolic activation therapy; coblation therapy of the soft tissues of the mouth, nose, throat, or tongue; computer assisted interpretation of xrays (except mammograms); extracorporeal shock wave therapy for musculoskeletal indications; cryoablation therapy for plantar fasciitis and Morton's neuroma; freestanding/home cervical traction; home anticoagulation or hemoglobin A1C testing; infrared light coagulation for the treatment of hemorrhoids,; interferential/neuromuscular stimulator; intimal media thickness testing to assess risk of coronary disease; lovaas therapy; magnetic source imaging; microprocessor controlled, computerized lower extremity limb prostheses; mole mapping; nonsurgical spinal decompression therapy; nucleoplasty or other forms of percutaneous disc decompression; pressure specified sensory device for neuropathy testing; prolotherapy; radiofrequency ablation for lateral epicondylitis; radiofrequency ablation of the dorsal root ganglion; secretin infusion therapy for the treatment of autism; virtual colonoscopy; whole

body scanning

29. Charges for provider telephone, email, or other electronic consultations

30. Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.

31. Cost associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.

32. Services for an illness, injury, or connected disability are not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any country

33. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP

34. Charges for educational material, literature or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as diet, or medication management for illnesses such as diabetes

35. Charges for services primarily for convenience, contentment or other non therapeutic purpose

36. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury

37. Charges which the insured is not, in the absence of coverage, legally

obligated to pay

38. Charges for services, treatments or supplies received as a result of an act of war occurring when the insured was covered by CHIP

39. Charges for any services received as a result of an industrial injury or illness, any portion of which is payable under workman's compensation or employer's liability laws

40. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony

41. Charges made for completion or submission of insurance forms

42. Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years

43. Shipping, handling, or finance charges

44. Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP as ineligible

45. Charges for expenses in connection with appointments scheduled and not kept

46. Charges for telephone calls or consultations-

47. Applied Behavior Analysis for the treatment of Autism Spectrum Disorder (ASD)

6.2.4.  **Surgical services** (Section 2110(a)(4))

## Scope of Coverage

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

## Exclusions

1. Surgery to facilitate weight loss is not covered. The reversal or revision of such procedures and services required for the treatment of complications from such procedures are not covered. However, medical or surgical complications that can be reasonably attributed to such a surgery will be considered for coverage if they arise ten years or more after the surgery.
2. Reconstructive, corrective, and cosmetic services provided for the following reasons are not covered:
  - a. To improve form or appearance
  - b. to correct a deformity, whether congenital or acquired, without restoring physical function
  - c. to cope with psychological factors such as poor self image or difficult social relations
  - d. the service is rendered within 12 months of the cause or onset of the injury, illness, or therapeutic intervention, or a planned, staged series of services is initiated within the 12 month period
  - e. to revise a scar, whether acquired through injury or surgery,



except when the primary purpose is to improve or correct a functional impairment

f. Breast reduction

g. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of services is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair

h. Port wine stain treatment

i. Sclerotherapy of superficial varicose veins

6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))

6.2.6.  **Prescription drugs** (Section 2110(a)(6))

#### Scope of Coverage

Prescribed drugs and preparations provided in a licensed pharmacy. Over the counter (OTC) drugs are not covered. Prescriptions must be medically necessary and may be limited to generic medications where medically acceptable. The DEPARTMENT advisory board of medical professionals may establish an approved list of covered name brand drugs, or a formulary/approved list of drugs will be developed by the Health Plan, reviewed and approved by the DEPARTMENT.

Prospective drug utilization review at the point of sale and

retrospective drug utilization review will be done by the health plan or its pharmacy benefit manager.

#### Exclusions

1. Appetite suppressants and weight loss medications
2. Certain off label drug usage, unless the use has been approved by a health plan medical director or clinical pharmacist
3. Compound drugs when alternative products are available commercially
4. Cosmetic health and beauty aids
5. Drugs purchased from nonparticipating providers over the internet
6. Flu symptom medications
7. Drugs and medications purchased through a foreign pharmacy, unless approved by the health plan
8. Human growth hormone for the treatment of idiopathic short stature
9. Infertility medications
10. Medications not meeting the minimum levels of evidence based upon FDA approval and/or DrugDex level IIa strength of recommendations, and National Comprehensive Cancer Network category 2A, if applicable.
11. Minerals, fluoride, and vitamins other than prenatal or when determined to be medically necessary to treat a specifically diagnosed disease

- 12. Nicotine and smoking cessations medications, except in conjunction with a health plan sponsored smoking cessations program
- 13. Over the counter medications, except as approved by the health plan
- 14. Prescription drugs used for cosmetic purposes
- 15. Prescriptions written by a licenses dentist, except for the prevention of infection or pain in conjunction with a dental procedure
- 16. Replacement of lost, stolen, or damaged drugs and medications
- 17. Sexual dysfunction medications
- 18. Travel related medications, including preventive medication for the purpose of travel to other countries.
- 19. Charges for unproven medical practices or care, treatment or drugs which are experimental or investigational in nature or generally considered experimental or investigational by the medical professional or non-FDA approved.

- 6.2.7.  Over-the-counter medications (Section 2110(a)(7))
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))

Scope of Coverage

Professional and technical laboratory and X-ray services furnished by licensed and certified providers. All laboratory testing sites providing services under this Contract must have either a Clinical

Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number.

Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

6.2.9.  Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))

Scope of Coverage

This service includes disseminating information, counseling, and treatments relating to family planning services. All services must be provided by or authorized by a physician, certified nurse midwife, or nurse practitioner. All services provided must include prior written consent of a minor's parent or legal guardian. All services must be provided in concert with Utah law.

The following family planning services are not covered:

- A. Norplant
- B. Infertility drugs
- C. In-vitro fertilization
- D. Genetic counseling

The Health Plan must ensure that high-risk pregnant Enrollees receive an appropriate level of quality prenatal care that is coordinated, comprehensive and continuous either by direct service or referral to an appropriate provider or facility.

- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))

Scope of Coverage

Inpatient and outpatient services are covered. Medically necessary services from contracted hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are covered. ~~Residential treatment is limited to 25 days per plan year.~~

- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))

Scope of Coverage

Inpatient and outpatient services are covered. Medically necessary services from contracted hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are

covered. ~~Residential treatment is limited to 25 days per plan year.~~

6.2.2.3-DC  HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

~~Delta Dental~~ Dental Select has the largest insured commercial enrollment and is the current benchmark.

Reference:

D0100-D0999 – Diagnostic

D1000-D1999 – Preventive

D2000-D2999 – Restorative

D3000-D3999 – Endodontics

D4000-D4999 – Periodontics

D5000-D5999 – Prosthodontics (Removable)

D6000-D6199 – Implant Services

D6200-D6999 – Prosthodontics, Fixed

D7000-D7999 – Oral and Maxillofacial Surgery

D8000-D8999 – Orthodontics

D9000-D9999 – Adjunctive General Services

Specifically, only the following dental services based on American Dental Association (ADA) codes are covered:

<u>D0120</u>	<u>D1351</u>	<u>D2544</u>	<u>D2910</u>	<u>D3348</u>	<u>D4355</u>	<u>D5721</u>	<u>D6603</u>	<u>D7260</u>	<u>D7530</u>	<u>D8040</u>
<u>D0140</u>	<u>D1352</u>	<u>D2610</u>	<u>D2915</u>	<u>D3351</u>	<u>D4910</u>	<u>D5730</u>	<u>D6604</u>	<u>D7261</u>	<u>D7540</u>	<u>D8050</u>
<u>D0145</u>	<u>D1353</u>	<u>D2620</u>	<u>D2920</u>	<u>D3352</u>	<u>D5110</u>	<u>D5731</u>	<u>D6605</u>	<u>D7270</u>	<u>D7550</u>	<u>D8060</u>
<u>D0150</u>	<u>D1510</u>	<u>D2630</u>	<u>D2921</u>	<u>D3353</u>	<u>D5120</u>	<u>D5740</u>	<u>D6606</u>	<u>D7280</u>	<u>D7560</u>	<u>D8070</u>
<u>D0160</u>	<u>D1516</u>	<u>D2642</u>	<u>D2929</u>	<u>D3410</u>	<u>D5130</u>	<u>D5741</u>	<u>D6607</u>	<u>D7282</u>	<u>D7610</u>	<u>D8080</u>
<u>D0170</u>	<u>D1517</u>	<u>D2643</u>	<u>D2930</u>	<u>D3421</u>	<u>D5140</u>	<u>D5750</u>	<u>D6624</u>	<u>D7283</u>	<u>D7620</u>	<u>D8090</u>
<u>D0171</u>	<u>D1520</u>	<u>D2644</u>	<u>D2931</u>	<u>D3425</u>	<u>D5211</u>	<u>D5751</u>	<u>D6634</u>	<u>D7285</u>	<u>D7630</u>	<u>D8210</u>
<u>D0180</u>	<u>D1526</u>	<u>D2650</u>	<u>D2932</u>	<u>D3426</u>	<u>D5212</u>	<u>D5760</u>	<u>D6720</u>	<u>D7286</u>	<u>D7640</u>	<u>D8220</u>
<u>D0210</u>	<u>D1527</u>	<u>D2651</u>	<u>D2933</u>	<u>D3430</u>	<u>D5213</u>	<u>D5761</u>	<u>D6721</u>	<u>D7290</u>	<u>D7670</u>	<u>D8660</u>
<u>D0220</u>	<u>D1550</u>	<u>D2652</u>	<u>D2934</u>	<u>D3450</u>	<u>D5214</u>	<u>D5820</u>	<u>D6722</u>	<u>D7291</u>	<u>D7710</u>	<u>D8680</u>
<u>D0230</u>	<u>D1555</u>	<u>D2662</u>	<u>D2940</u>	<u>D3920</u>	<u>D5225</u>	<u>D5821</u>	<u>D6750</u>	<u>D7310</u>	<u>D7720</u>	<u>D8690</u>
<u>D0240</u>	<u>D1575</u>	<u>D2663</u>	<u>D2950</u>	<u>D4210</u>	<u>D5226</u>	<u>D5850</u>	<u>D6751</u>	<u>D7311</u>	<u>D7730</u>	<u>D8691</u>
<u>D0270</u>	<u>D2140</u>	<u>D2664</u>	<u>D2951</u>	<u>D4211</u>	<u>D5410</u>	<u>D5851</u>	<u>D6752</u>	<u>D7320</u>	<u>D7740</u>	<u>D8693</u>
<u>D0272</u>	<u>D2150</u>	<u>D2710</u>	<u>D2952</u>	<u>D4212</u>	<u>D5411</u>	<u>D5863</u>	<u>D6780</u>	<u>D7321</u>	<u>D7910</u>	<u>D8694</u>
<u>D0273</u>	<u>D2160</u>	<u>D2712</u>	<u>D2953</u>	<u>D4240</u>	<u>D5421</u>	<u>D5864</u>	<u>D6781</u>	<u>D7340</u>	<u>D7911</u>	<u>D8695</u>
<u>D0274</u>	<u>D2161</u>	<u>D2720</u>	<u>D2954</u>	<u>D4241</u>	<u>D5422</u>	<u>D5865</u>	<u>D6782</u>	<u>D7350</u>	<u>D7912</u>	<u>D8999</u>
<u>D0277</u>	<u>D2330</u>	<u>D2721</u>	<u>D2957</u>	<u>D4245</u>	<u>D5511</u>	<u>D5866</u>	<u>D6790</u>	<u>D7410</u>	<u>D7920</u>	<u>D9110</u>
<u>D0330</u>	<u>D2331</u>	<u>D2722</u>	<u>D2980</u>	<u>D4249</u>	<u>D5512</u>	<u>D6210</u>	<u>D6791</u>	<u>D7411</u>	<u>D7950</u>	<u>D9222</u>
<u>D0340</u>	<u>D2332</u>	<u>D2740</u>	<u>D3220</u>	<u>D4260</u>	<u>D5520</u>	<u>D6211</u>	<u>D6792</u>	<u>D7412</u>	<u>D7960</u>	<u>D9223</u>
<u>D0350</u>	<u>D2335</u>	<u>D2750</u>	<u>D3221</u>	<u>D4261</u>	<u>D5611</u>	<u>D6212</u>	<u>D6794</u>	<u>D7413</u>	<u>D7970</u>	<u>D9239</u>
<u>D0460</u>	<u>D2390</u>	<u>D2751</u>	<u>D3222</u>	<u>D4263</u>	<u>D5612</u>	<u>D6214</u>	<u>D6930</u>	<u>D7414</u>	<u>D7971</u>	<u>D9243</u>
<u>D0470</u>	<u>D2391</u>	<u>D2752</u>	<u>D3230</u>	<u>D4264</u>	<u>D5621</u>	<u>D6240</u>	<u>D6940</u>	<u>D7450</u>	<u>D7979</u>	<u>D9310</u>
<u>D0472</u>	<u>D2392</u>	<u>D2780</u>	<u>D3240</u>	<u>D4266</u>	<u>D5622</u>	<u>D6241</u>	<u>D7111</u>	<u>D7451</u>	<u>D7980</u>	<u>D9440</u>
<u>D0473</u>	<u>D2393</u>	<u>D2781</u>	<u>D3310</u>	<u>D4267</u>	<u>D5630</u>	<u>D6242</u>	<u>D7140</u>	<u>D7460</u>	<u>D7981</u>	<u>D9951</u>
<u>D0474</u>	<u>D2394</u>	<u>D2782</u>	<u>D3320</u>	<u>D4270</u>	<u>D5640</u>	<u>D6250</u>	<u>D7210</u>	<u>D7461</u>	<u>D7982</u>	<u>D9999</u>
<u>D0485</u>	<u>D2510</u>	<u>D2783</u>	<u>D3330</u>	<u>D4276</u>	<u>D5650</u>	<u>D6251</u>	<u>D7220</u>	<u>D7465</u>	<u>D7983</u>	
<u>D1110</u>	<u>D2520</u>	<u>D2790</u>	<u>D3332</u>	<u>D4277</u>	<u>D5660</u>	<u>D6252</u>	<u>D7230</u>	<u>D7471</u>	<u>D7999</u>	
<u>D1120</u>	<u>D2530</u>	<u>D2791</u>	<u>D3333</u>	<u>D4278</u>	<u>D5710</u>	<u>D6545</u>	<u>D7240</u>	<u>D7510</u>	<u>D8010</u>	
<u>D1206</u>	<u>D2542</u>	<u>D2792</u>	<u>D3346</u>	<u>D4341</u>	<u>D5711</u>	<u>D6549</u>	<u>D7241</u>	<u>D7511</u>	<u>D8020</u>	
<u>D1208</u>	<u>D2543</u>	<u>D2794</u>	<u>D3347</u>	<u>D4342</u>	<u>D5720</u>	<u>D6602</u>	<u>D7250</u>	<u>D7520</u>	<u>D8030</u>	

<b>D0120</b>	<b>D0602</b>	<b>D2542</b>	<b>D2792</b>	<b>D3333</b>	<b>D4341</b>	<b>D5731</b>	<b>D6069</b>	<b>D6242</b>	<b>D7220</b>	<b>D7471</b>	<b>D8030</b>
<b>D0140</b>	<b>D0603</b>	<b>D2543</b>	<b>D2794</b>	<b>D3346</b>	<b>D4342</b>	<b>D5741</b>	<b>D6070</b>	<b>D6250</b>	<b>D7230</b>	<b>D7520</b>	<b>D8040</b>

D0145	D1110	D2544	D2910	D3347	D4910	D5750	D6071	D6252	D7240	D7530	D8050
D0150	D1120	D2610	D2915	D3348	D5110	D5751	D6073	D6545	D7241	D7540	D8060
D0160	D1206	D2620	D2920	D3351	D5120	D5760	D6074	D6549	D7250	D7550	D8070
D0170	D1208	D2630	D2921	D3353	D5130	D5761	D6075	D6602	D7260	D7560	D8080
D0171	D1351	D2642	D2929	D3410	D5140	D5820	D6076	D6603	D7261	D7610	D8090
D0180	D1352	D2643	D2930	D3421	D5211	D5821	D6077	D6604	D7270	D7620	D8210
D0190	D1353	D2644	D2931	D3425	D5212	D5850	D6092	D6605	D7280	D7630	D8220
D0191	D1510	D2650	D2932	D3426	D5213	D5851	D6093	D6606	D7282	D7640	D8660
D0210	D1515	D2651	D2934	D3430	D5214	D5863	D6094	D6607	D7283	D7670	D8680
D0220	D1520	D2652	D2940	D3450	D5225	D5864	D6101	D6624	D7285	D7710	D8690
D0230	D1525	D2662	D2941	D3920	D5226	D5866	D6102	D6634	D7286	D7720	D8691
D0240	D1550	D2663	D2949	D4210	D5281	D6010	D6103	D6720	D7291	D7730	D8692
D0250	D1555	D2664	D2950	D4211	D5410	D6040	D6104	D6721	D7310	D7740	D8693
D0260	D2140	D2710	D2951	D4212	D5411	D6050	D6110	D6722	D7311	D7910	D8680
D0270	D2150	D2712	D2952	D4240	D5421	D6055	D6111	D6750	D7320	D7911	D8694
D0272	D2160	D2720	D2953	D4241	D5422	D6056	D6112	D6751	D7321	D7912	D8999
D0273	D2161	D2721	D2954	D4245	D5510	D6057	D6113	D6752	D7340	D7920	D9110
D0274	D2330	D2722	D2957	D4249	D5520	D6058	D6114	D6780	D7350	D7950	D9219
D0277	D2331	D2740	D2980	D4260	D5610	D6059	D6115	D6781	D7410	D7960	D9220
D0330	D2332	D2750	D3220	D4261	D5630	D6060	D6116	D6782	D7411	D7970	D9221
D0340	D2335	D2751	D3221	D4263	D5640	D6061	D6117	D6790	D7412	D7971	D9241
D0350	D2390	D2752	D3222	D4264	D5650	D6062	D6194	D6791	D7413	D7980	D9242
D0460	D2391	D2780	D3230	D4266	D5660	D6063	D6210	D6792	D7414	D7981	D9310
D0470	D2392	D2781	D3240	D4267	D5710	D6064	D6211	D6930	D7450	D7982	D9940
D0472	D2393	D2782	D3310	D4270	D5711	D6065	D6212	D6940	D7451	D7983	D9951
D0473	D2394	D2783	D3320	D4273	D5720	D6066	D6214	D7111	D7460	D7999	D9999
D0485	D2520	D2790	D3330	D4277	D5721	D6067	D6240	D7140	D7461	D8010	

### 8.2.3. Coinsurance or copayments:

The following are the co-payment and co-insurance requirements for participation in CHIP. Levels of co-payments will be limited to the income groups identified in the federal enabling legislation 2103(e)(3)(A) & (B).

#### Plan B Co-Payment requirements:



Hospital Services:

\$150 co-payment after deductible for inpatient services.

Co-insurance, 5% for surgeon and anesthesiologist services.

\$5 co-payment for urgent care center services and emergency use of the emergency room.

\$10 co-payment for non emergency use of the emergency room

Co-insurance, 5% after deductible for outpatient hospital services.

Ambulance (air and ground) for medical emergencies:

Co-insurance, 5% after deductible

Physician Office Visits (includes visits to a Specialist):

\$5 co-payment per visit.

No co-payment for well-baby care, well-child care, and immunizations.

Prescription Drugs:

\$5 co-payment per prescription for generics

Co-insurance, 5% per prescription for brand name drugs.

Laboratory and X-ray Services:

\$0 co-payment for laboratory and x-ray services for minor diagnostic tests and x-rays

Co-insurance, 5% after deductible for major diagnostic tests and x-rays

Vision Screening Services:

\$5 co-payment (limit of one exam per plan year).

Hearing Screening Services:

\$5 co-payment (limit of one exam per plan year).

Dental Services :

Maximum benefit of \$1,000 per person, per year

\$0 co-payment for cleanings, exams, x-rays, fluoride, and sealants.

5% co-insurance for all other covered services.

Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index

Mental Health Services, Inpatient ~~& Outpatient~~ Facility:

\$150 co-payment after deductible for each visit

Mental Health Services, Outpatient & Office Visit :

~~\$5~~0 co-payment for each visit

Home Health and Hospice Care:

Co-insurance of 5% after deductible per visit.

Medical Equipment and Supplies:

Co-insurance of 5% after deductible

Physical, Occupational and Speech Therapy:

\$5 co-payment, 20 visits combined limit per child, per plan year.

Out- of-Pocket Maximum:

5% of a family's annual gross countable income. Only out of pocket costs for covered services, deductibles, co-pays, and premiums will be used to calculate the maximum out of pocket limit.

**Plan C Co-Insurance and Co-Payment requirements:**

**Hospital Services:**

Co-insurance, 20% after deductible for inpatient services

\$300 co-payment for emergency or non-emergency use of the emergency room, after deductible ; \$300 per visit for non participating hospitals, after deductible

\$40 co-payment each urgent care center visit

Co-insurance of 20% of total charges for surgeon and anesthesiologist services, after deductible.

Co-insurance, 20% after deductible for outpatient services.

**Ambulance (air and ground) for medical emergencies:**

Co-insurance, 20% after deductible

**Physician office visits:**

\$25 co-payment per visit (excluding visits to a Specialist)

\$40 co-payment per visit to a Specialist.

No co-payment for well-baby care, well-child care and immunizations.

Prescription Drugs:

\$15 co-payment per prescription for generic drugs; Co-insurance 25% of total or brand name drugs on the approved list. Co-insurance 50% of total per prescription for brand name drugs not on the approved list.

Laboratory and X-Ray Services:

\$0 co-payment for minor diagnostic tests and x-rays.

Co-insurance, 20% after deductible for major diagnostic tests and x-rays.

Vision Screening Services:

\$25 co-payment, limit of one exam per plan year.

Hearing Screening Services:

\$25 co-payment, limit of one exam per plan year.

## Dental Services:

Maximum benefit of \$1,000 per person, per year.

Plan pays 100% for cleanings, exams, x-rays, fluoride, and sealants.

Co-insurance, 20% after deductible for all other covered services.

Co-insurance, 50% after deductible for porcelain-fused crowns (not Covered for non-adult and back teeth).

Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index.

## Mental Health Services In-Patient ~~& Outpatient~~ Facility

Co-insurance, 20% after deductible.

## Mental Health Services Outpatient & Office Visit

\$40 co-payment for each visit

## Home Health and Hospice Care:

Co-insurance, 20% after deductible

Medical Equipment and Supplies:

Co-insurance, 20% after deductible

Physical, Occupational and Speech Therapy:

\$40 co-payment after deductible, 20 visits combined limit, per child, per plan year.

Out-of-Pocket Maximum

The maximum out of pocket expense is 5% of a family's annual gross income. Only out of pocket costs for covered services, deductibles, co-pays, and premiums will be used to calculate the maximum out of pocket limit.

**Co-Insurance and Co-payment requirements for CHIP clients/enrollees who are Native American.**

No co-payments or premiums are charged to CHIP enrollees who are Native American.