UTAH DEPARTMENT OF HEALTH CONTRACT AMENDMENT

PO Box 144003, Salt Lake City, Utah 84114
288 North 1460 West, Salt Lake City, Utah 84116

1601106	156146
Department Log Number	State Contract Number

1. CONTRACT NAME: The name of this contract is CHIP - Molina Healthcare of Utah Amendment 1.

2. CONTRACTING PARTIES: This contract amendment is between the Utah Department of Health (DEPARTMENT) and MOLINA HEALTHCARE OF UTAH (CONTRACTOR).

3. PURPOSE OF CONTRACT AMENDMENT: To update rates and covered services effective 10/01/2015.

4. CHANGES TO CONTRACT:

    1. --Attachment C amendment-- Removed reference to CHIP Plan A.
    2. --Attachment F-- Updated Rates.

All other conditions and terms in the original contract and previous amendments remain the same.

5. EFFECTIVE DATE OF AMENDMENT: This amendment is effective [10/01/2015]

6. DOCUMENTS INCORPORATED INTO THIS CONTRACT BY REFERENCE BUT NOT ATTACHED:
    A. All other governmental laws, regulations, or actions applicable to services provided herein.
    B. All Assurances and all responses to bids as provided by the CONTRACTOR.

7. This contract, its attachments, and all documents incorporated by reference constitute the entire agreement between the parties and supersedes all prior written or oral agreements between the parties relating to the subject matter of this contract.

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Contract with Utah Department of Health and MOLINA HEALTHCARE OF UTAH, Log # 1601106

IN WITNESS WHEREOF, the parties enter into this agreement.

CONTRACTOR

By: [redacted] 1/19/2016
David Patton Date
President

STATE

By: [redacted] 1/21/2016
Shari A. Watkins, C.P.A. Date
Director, Office Fiscal Operations

[redacted] 1/25/16
State Purchasing Date

CONTRACT RECEIVED AND
PROCESSED BY
DIVISION OF FINANCE

JAN 26 2016

Covered Services, Limitations, Exclusions and Co-Payment Requirements

SECTION 1: Covered Services

The Contractor shall provide the following benefits to CHIP Enrollees in accordance with benefits as defined in the Utah Children's Health Insurance Program State Plan subject to the exclusions or limitations noted in this attachment. The Department reserves the right to interpret what is in the State Plan. CHIP covered services can only be limited through utilization criteria based on medical necessity. The Contractor's Health Plan shall provide at least the following benefits to CHIP Enrollees.

The Contractor is responsible to provide or arrange for all appropriate covered services on an emergency basis 24 hours each day, seven days a week. The Contractor is responsible for payment for all covered emergency services furnished by Non-Participating Providers.

1.1 Hospital Services

A. Inpatient Hospital

Services furnished in a licensed, certified hospital.

B. Outpatient Hospital

Services provided to Enrollees at a licensed, certified hospital who are not admitted to the hospital.

C. Emergency Department Services

Emergency services provided to Enrollees in designated hospital emergency departments.

1.2 Physician Services

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.

1.3 Vision Care

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice.

Services include:

A. Routine vision examinations.

B. One exam every 12 months.

1.4 Lab and Radiology Services

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.

1.5 Physical Therapy/ Occupational Therapy

Treatment and services provided by a licensed physical or occupational therapist. A physician must authorize treatment and services for physical or occupational therapy.

1.6 Chiropractic Services

This is not a covered benefit.

1.7 Hearing Services

Screening services provided by a licensed medical professional/audiologist to test for any hearing loss. One exam every 12 months.

Bilateral cochlear implants are covered up to a lifetime maximum of $35,000. The surgery itself (facility, anesthesia, physician's fees, etc.) and the implant device apply to this limit. Aural rehabilitation related to an approved cochlear implantation is subject to speech therapy benefit limitations but does not apply to the maximum plan payment. Maintenance on the device, such as replacement batteries, is a covered service and does not apply to

the maximum plan payment, whether or not the implant was performed while covered by CHIP.

1.8 Podiatry Services

Services provided by a licensed podiatrist.

1.9 End Stage Renal Disease - Dialysis

Treatment of end stage renal failure by dialysis. Dialysis is to be rendered by a Medicare-certified Dialysis facility.

1.10 Home Health Services

Home health services are defined as intermittent nursing care provided by certified nursing professionals (registered nurses and licensed practical nurses) in the Enrollee's home when the Enrollee is homebound or semi-homebound. Home health care is to be rendered by a Medicare-certified Home Health Agency.

1.11 Speech Therapy

Services provided by a licensed speech language pathologist if therapy is to restore speech loss or to correct impairment if due to a congenital defect or an injury or sickness.

1.12 Hospice Services

Services delivered to terminally ill patients (six months life expectancy) who elect to receive palliative care. Hospice care is to be rendered by a Medicare-certified hospice. Hospice services are available to clients without them forgoing any other service including curative treatment to which they are entitled under this contract. [Reference: Affordable Care Act, Section 2302, SMD # 10-018]

1.13 Durable Medical Equipment and Supplies

Equipment and appliances used to assist the patient's medical recovery, including both durable and non-durable medical supplies and equipment. Durable medical equipment includes, but is not limited to, prosthetic devices.

1.14 Abortions and Sterilizations

These services are provided to the extent permitted by Federal and State law and must meet the documentation requirement of 42 CFR 441, Subparts E and F. Abortion services to unmarried minors must have written notification of the parent or legal guardian.

1.15 Organ Transplants

The following transplantations are covered for all Enrollees:

A. bone marrow
B. combined heart/lung
C. combined pancreas/kidney
D. cornea
E. heart
F. kidney
G. liver
H. pancreas after kidney
I. single or double lung

1.16 Other Outside Medical Services

The Contractor, at its discretion and without compromising quality of care, may choose to provide services in Freestanding Emergency Centers, Surgical Centers and Birthing Centers.

1.17 Transportation Services

Ambulance (ground and air) service for medical emergencies.

1.18 Preventive Services (Well-Child Care)

The Contractor shall provide to CHIP Enrollees preventive screening services, including routine physical examinations and immunizations.

The Contractor shall provide preventive services to all eligible children and young adults up to age 19 in accordance with the American Academy of Pediatrics (AAP) periodicity schedules.

The Contractor agrees to educate and encourage compliance with the AAP periodicity schedules. These efforts will include education and compliance monitoring for children and young adults, taking into account the multi-lingual, multi-cultural nature as well as other unique characteristics of the CHIP Enrollees.

1.19 Family Planning Services

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 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

1.20 Pharmacy Services

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 Contractor, 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 Contractor or its pharmacy benefit manager.

1.21 Mental Health

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.

1.22 Medical and Surgical Services of a Dentist

Dental Services

Dental services are covered in the following limited circumstances:

A. When rendered to diagnose or treat medical complications of a dental procedure and administered under the direction of a medical provider whose primary practice is not dentistry or oral surgery.

B. When the Contractor determines the following to be medically necessary:

i. Maxillary and/or mandibular procedures;

ii. Upper/lower jaw augmentation or reduction procedures, including developmental corrections or altering of vertical dimension; and

iii. Orthognathic Services.

C. For repairs of physical damage to sound natural teeth, crowns, and the supporting structures surrounding teeth when:

i. Such damage is a direct result of an accident independent of disease or bodily infirmity or any other cause;

ii. Medical advice, diagnosis, care, or treatment was recommended or received for the injury at the time of the accident; and

iii. Repairs are initiated within one year of the date of the accident.

Orthodontia and the replacement/repair of dental appliances are not covered, even after an accident. Repairs for physical damage resulting from biting or chewing are not covered.

Unless stated otherwise above, services rendered to the teeth, the tooth pulp, the gums, or the bony structure supporting the teeth are not covered.

Dental Anesthesia

See section 2.16, Dental Anesthesia, for circumstances where dental anesthesia is covered.

1.23 High-Risk Prenatal Services

The Contractor 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.

1.24 Services for Children with Special Needs

In addition to primary care, children with chronic illnesses and disabilities need specialized care provided by trained experienced professionals. Since early diagnosis and intervention will prevent costly complications later on, the specialized care must be provided in a timely manner. The specialized care must comprehensively address all areas of need to be most

effective and must be coordinated with primary care and other services to be most efficient. The children's families must be involved in the planning and delivery of the care for it to be acceptable and successful.

Therefore all children with special health care needs must have timely access to the following services:

A. Comprehensive evaluation for the condition.

B. Pediatric sub-specialty consultation and care appropriate to the condition.

C. Rehabilitative services provided by professionals with pediatric training in areas such as physical therapy, occupational therapy and speech therapy.

D. Durable medical equipment appropriate for the condition.

E. Care coordination for linkage to early intervention, special education and family support services and for tracking progress.

In addition, children with the conditions marked by * below must have timely access to coordinated multi-specialty clinics, when medically necessary, for their disorder.

The definition of children with special health needs includes, but is not limited to, the following conditions:

1. Nervous System Defects such as

   Spina Bifida*

   Sacral Agenesis*

   Hydrocephalus

2. Craniofacial Defects such as

   Cleft Lip and Palate*

   Treacher - Collins Syndrome

3. Complex Skeletal Defects such as
    - Arthrogryposis*
    - Osteogenesis Imperfecta*
    - Phocomelia*

4. Inborn Metabolic Disorders such as
    - Phenylketonuria*
    - Galactosemia*

5. Neuromotor Disabilities such as
    - Cerebral palsy*
    - Muscular Dystrophy*
    - Complex Seizure Disorders

6. Congenital Heart Defects

7. Genetic Disorders such as
    - Chromosome Disorders
    - Genetic Disorders

8. Chronic Illnesses such as
    - Cystic Fibrosis
    - Hemophilia
    - Rheumatoid Arthritis
    - Bronchopulmonary Dysplasia
    - Cancer
    - Diabetes
    - Nephritis
    - Immune Disorders

9. Developmental Disabilities with multiple or global delays in development such as Down Syndrome or other conditions associated with mental retardation.

1.25 Facility Charges for Dental Procedures

The Contractor is responsible to pay for the cost of the facility when a member qualifies to receive dental anesthesia under Section 2.16.

SECTION 2: Limitations and Exclusions

Unless otherwise noted in this attachment as specifically covered, the following Limitations and Exclusions apply.

2.1 Abortions/Termination of Pregnancy

Abortions are not covered except:

A. When a physician has found that the abortion is necessary to save the life of the mother; or

B. Where the pregnancy resulted from an act of rape or incest.

2.2 Acupuncture/Acupressure

Acupuncture and acupressure Services are not covered.

2.3 Administrative Services/Charges

Services obtained for administrative purposes are not covered. 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 are not covered.

2.4 Allergy Tests/Treatments

The following allergy tests are not covered:

A. Cytotoxic Test (Bryan's Test)
B. Leukocyte Histamine Release Test
C. Mediator Release Test (MRT)
D. Passive Cutaneous Transfer Test (P—K Test)
E. Provocative Conjunctival Test
F. Provocative Nasal Test
G. Rebuck Skin Window Test
H. Rinkel Test
I. Subcutaneous Provocative Food and Chemical Test
J. Sublingual Provocative Food and Chemical Test

The following allergy treatments are not covered:

K. Allergoids
L. Autogenous urine immunization
M. LEAP therapy
N. Medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.)
O. Neutralization therapy
P. Photo—inactivated extracts
Q. Polymerized extracts
R. Oral desensitization/immunotherapy

2.5 Anesthesia

General anesthesia rendered in a Provider's office is not covered.

2.6 Attention—Deficit/Hyperactivity Disorder

Cognitive or behavioral therapies for the treatment of these disorders are not covered.

2.7 Bariatric Surgery

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.

2.8 Biofeedback/Neurofeedback

Biofeedback/neurofeedback is not covered.

2.9 Birthing Centers and Home Childbirth

Childbirth in any place other than a Hospital is not covered. This includes all Provider and/or Facility charges related to the delivery.

2.10 Certain Cancer Therapies

The following cancer therapies are not covered:

A. Neutron beam therapy
B. Proton beam therapy

2.11 Certain Illegal Activities

Services for an illness, condition, accident, or injury are not covered if it 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:

   i. 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
   ii. Had any illegal drug or other illegal substance in the Member's body to a degree that it affected the Member's ability to drive or operate the vehicle safely;

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; or

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.

The presence of drugs or alcohol may be determined by tests performed by or for law enforcement, tests performed during diagnosis or treatment, or by other reliable means.

2.12 Claims After One Year

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.

2.13 Complementary and Alternative Medicine (CAM)

Complementary, alternative and nontraditional Services are not covered. Such Services include acupuncture, homeopathy, homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography.

2.14 Complications

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

2.15 Custodial Care

Custodial Care is not covered.

2.16 Dental Anesthesia

Services including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at participating facilities when members meet the following criteria:

A. The member is developmentally delayed, regardless of the chronological age of the member:

B. The member, regardless of age, has a congenital cardiac or neurological condition and provides documentation that the dental anesthesia is needed to closely monitor the condition; or

C. The member is younger than five years of age and:
   i. The proposed dental work involves three or more teeth;
   ii. The diagnosis is nursing bottle-mouth syndrome or extreme enamel hypoplasia; and
   iii. The proposed procedures are restoration or extraction for rampant decay.

Cardiac/Neurologic Conditions

Consideration of coverage will be given to members, regardless of age, with congenital cardiac or neurological conditions. The member must provide documentation describing that the need for dental anesthesia is due to an underlying medical condition and the associated requirement to closely monitor this condition.

Dental anesthesia for conditions such as ADHD, situational anxiety, or fear of dentists is not covered.

Note: Remember, general anesthesia rendered with an office surgery is not covered.

2.17 Exclusion Deleted

2.18 Dry Needling

Dry needling procedures are not covered.

2.19 Duplication of Coverage

The following are not covered:

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

B. 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.

2.20 Experimental and/or Investigational Services

Experimental and/or Investigational Services are not covered. An Experimental and/or Investigational Service is a service for which one or more of the following apply:

A. 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;

B. It is the subject of a current investigational new drug or new device application on file with the FDA;

C. 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;

D. 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); or

E. If the predominant opinion among 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.

2.21 Eye Surgery, Refractive

Radial keratotomy, LASIK, or other eye surgeries performed primarily to correct refractive errors are not covered.

2.22 Fitness Training

Fitness training, conditioning, exercise equipment, and membership fees to a spa or health club are not covered.

2.23 Food Supplements

Except for Dietary Products as defined by the Contractor, food supplements and substitutes are not covered.

2.24 Gene Therapy

Gene therapy or gene-based therapies are not covered.

2.25 Habilitation Therapy Services

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

2.26 Hearing Aids

Except for cochlear implants, the purchase, fitting, or ongoing evaluation of hearing aids, appliances, auditory brain implants, bone—anchored hearing aids, or any other procedure or device intended to establish or improve hearing or sound recognition is not covered.

2.27 Home Health Aides

Services provided by a home health aide are not covered.

2.28 Immunizations

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

2.29 Exclusion Deleted

2.30 Methadone Therapy

Methadone maintenance/therapy clinics or Services are not covered.

2.31 Noncovered Service in Conjunction with a Covered Service

When a noncovered 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 noncovered Service.

2.32 Pain Management Services

The following Services are not covered:

A. Prolotherapy
B. Radiofrequency ablation of dorsal root ganglion
C. Acupuncture
D. IV pamidronate therapy for the treatment of reflex sympathetic dystrophy

2.33 Pervasive Developmental Disorder

Services for Pervasive Developmental Disorder are not covered.

2.34 Exclusion Removed

2.35 Prescription Drugs/Injectable Drugs and Specialty Medications.

The following are not covered:

A. Appetite suppressants and weight loss medications;
B. Certain off-label drug usage, unless the use has been approved by a Health Plan Medical Director or clinical pharmacist;
C. Compound drugs when alternative products are available commercially;
D. Cosmetic health and beauty aids;
E. Drugs purchased from Nonparticipating Providers over the Internet;
F. Flu symptom medications;
G. Drugs and medications purchased through a foreign pharmacy, unless approved by the Contractor.
H. Human growth hormone for the treatment of idiopathic short stature;
I. Infertility medications;
J. Medications not meeting the minimum levels of evidence based upon Food and Drug Administration (FDA) approval and/or DrugDex level IIa strength of recommendation, and National Comprehensive Cancer Network (NCCN) category 2A, if applicable.
K. Minerals, fluoride, and vitamins other than prenatal or when determined to be Medically Necessary to treat a specifically diagnosed disease;
L. Nicotine and smoking cessation medications, except in conjunction with a – Contractor-sponsored smoking cessation program;
M. Over-the-counter (OTC) medications, except as approved by the Contractor;
N. Prescription Drugs used for cosmetic purposes;
O. Prescriptions written by a licensed dentist, except for the prevention of infection or pain in conjunction with a dental procedure;
P. Replacement of lost, stolen, or damaged drugs and medications;
Q. Sexual dysfunction medications; and
R. Travel-related medications, including preventive medication for the purpose of travel to other countries.

2.36 Reconstructive, Corrective, and Cosmetic Services

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 (as specifically documented in the member's medical record) 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 (except according to Contractor criteria);
G. Congenital cleft lip except for treatment rendered within 12 months of birth, or a planned, staged series of Services (as specifically documented in the Member's medical record) is initiated, or when congenital cleft lip surgery is performed as part of a cleft palate repair;
H. Port wine stain treatment (except according to Contractor criteria);
I. Sclerotherapy of superficial varicose veins (spider veins);

2.37 Rehabilitation Therapy Services

The following are not covered:

A. Services for functional nervous disorders;
B. Vision rehabilitation therapy Services;
C. Speech therapy for developmental speech delay.

2.38 Related Provider Services

Services provided to a Member by a Provider who ordinarily resides in the same household as the Member are not covered.

2.39 Respite Care

Respite Care is not covered.

2.40 Sexual Dysfunction

Services related to sexual dysfunction are not covered.

2.41 Specialty Services

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.

2.42 Specific Services

The following Services are not covered:

A. Anodyne infrared device for any indication
B. Auditory brain implantation
C. Chronic intermittent insulin IV therapy/metabolic activation therapy
D. Coblation therapy of the soft tissues of the mouth, nose, throat, or tongue
E. Computer-assisted interpretation of x-rays (except mammograms)
F. Extracorporeal shock wave therapy for musculoskeletal indications
G. Cryoablation therapy for plantar fasciitis and Morton's neuroma
H. Freestanding/home cervical traction
I. Home anticoagulation or hemoglobin A1C testing
J. Infrared light coagulation for the treatment of hemorrhoids
K. Interferential/neuromuscular stimulators
L. Intimal Media Thickness (IMT) testing to assess risk of coronary disease
M. Lovaas therapy
N. Magnetic Source Imaging (MSI)
O. Microprocessor controlled, computerized lower extremity limb prostheses
P. Mole mapping
Q. Nonsurgical spinal decompression therapy (e. g. , VAX-D or DRS therapy)
R. Nucleoplasty or other forms of percutaneous disc decompression
S. Pressure Specified Sensory Device (PSSD) for neuropathy testing
T. Prolotherapy
U. Radiofrequency ablation for lateral epicondylitis
V. Radiofrequency ablation of the dorsal root ganglion
W. Secretin infusion therapy for the treatment of autism
X. Virtual colonoscopy
Y. Whole body scanning

2.43 Telephone/E-mail Consultations

Charges for Provider telephone, e-mail, or other electronic consultations are not covered.

2.44 Terrorism or Nuclear Release

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.

2.45 Travel-Related Expenses

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

2.46 Exclusion Deleted

2.47 War

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.

2.48 Orthotics and Other Corrective Appliances for the Foot

Not covered unless they are part of a lower foot brace, and they are prescribed as part of a specific treatment associated with recent, related surgery.

2.49 General Exclusions

A. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP.
B. 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.
C. Charges for services primarily for convenience, contentment or other non-therapeutic purpose.
D. 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 profession or non-FDA approved.
E. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury.
F. Charges which the insured is not, in the absence of coverage, legally obligated to pay.
G. Charges for services, treatments or supplies furnished by a hospital or facility owned or operated by the United States Government or any agency thereof.
H. Charges for services, treatments or supplies received as a result of an act of war occurring when the insured is covered by CHIP.
I. Charges for any services received as a result of an industrial (on the job) injury or illness, any portion of which is payable under workman's compensation or employer's liability laws.
J. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony.
K. Charges made for completion or submission of insurance forms.
L. 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.

M. Shipping, handling, or finance charges.
N. Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP to be ineligible.
O. Charges for expenses in connection with appointments scheduled and not kept.
P. Charges for telephone calls or consultations.

SECTION 3: Co-Insurance and Co-Payment Requirements for CHIP Enrollees from 134 to 150% of the Federal Poverty Level

(PLAN B)

3.1 Hospital Services (inpatient, outpatient and emergency department)

$150 co-payment, after deductible for allowable inpatient hospital services

Plan pays 95%, after deductible for ambulatory surgical and outpatient hospital services

Plan pays 95% for surgeon and anesthesiologist services

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

For all other hospital services

$5 co-payment per visit

3.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits

$5 co-payment per visit

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

20 visit combined limit per plan year on physical, occupational, and speech therapy

Chiropractic visits are not covered

3.3 Laboratory and X-Ray Services

For laboratory services $350 and under (of allowable charges)*:	No co-payment
For laboratory services above $350 (of allowable charges)**:	Co-insurance, 5% of allowed amount after deductible
For X-ray services $350 and under (of allowable charges)*:	No co-payment

For X-ray services above $350 (of allowable charges)**:	Co-insurance, 5% of allowed amount after deductible

Instead of by dollar amount, the Contractor may choose to group these diagnostic tests as Major** (corresponding to the above $350 co-pay category) and Minor *(corresponding to the $350 and under category) and have co-payment schedules reflecting those same categorizations. These groups shall be closely based on allowable charges for (1) those $350 and under and (2) over $350.

3.4 Prescription Drugs

For generic drugs on an approved list:	$5 co-payment per prescription
For all other drugs:	Co-insurance, 5% of allowed amount

3.5 Vision Screening Services

$5 co-payment, limit of one exam every 12 months.

3.6 Hearing Screening Services

$5 co-payment, limit of one exam every 12 months.

3.7 Durable Medical Equipment and Supplies

Co-insurance, 5% of allowed amount after deductible

3.8 Mental Health Services

3.8.1 Inpatient and Outpatient Facility:

$150 co-payment, after deductible

3.8.2 Office Visit:

No co-payment

3.8.3 Residential Treatment:

Co-insurance, 5% of allowed amount after deductible, limit of 25 visits per plan year

3.9 Ambulance - Ground and Air

Co-insurance, 5% of allowed amount after deductible

3.10 Home Health and Hospice Care

Co-insurance, 5% of allowed amount after deductible

3.11 Deductible

Plan B enrollees are required to pay $40 per family per year.

3.12 Pre-existing Condition Waiting Period

No waiting period

3.13 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the Department. Upon request, the Contractor will provide the Department with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the Department, the Contractor will switch the family to a no out-of-pocket payment (exempt) option, will reimburse the family for any excess amount paid above 5% and will mail new identification cards to the family.

NOTE: **The allowed amount is (1) the contract rate that the Contractor has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.**

SECTION 4: Co-Insurance and Co-Payment Requirements for CHIP Enrollees 151%-200% of the Federal Poverty Level

(PLAN C)

4.1 Hospital Services (inpatient, outpatient and emergency department)

Co-insurance, 20% of allowed amount after deductible, for inpatient, outpatient, and ambulatory surgical services

Plan pays 80% for surgeon and anesthesiologist services, after deductible

$300 co-payment for each participating emergency department visit, after deductible

$300 co-payment for each non-participating emergency department visit, after deductible

4.2 Outpatient Office Visits

This includes physician (inpatient and outpatient), physician-related, urgent care, physical and occupational therapy, speech therapy, and podiatry visits

For physician visits	$25 co-payment per visit
Therapy visits (Physical, occupational and speech):	$40 co-payment per visit after deductible
For all other outpatient office visits Including specialists and urgent care:	$40 co-payment per visit

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

20 visit combined limit per plan year on physical, occupational, and speech therapy

Chiropractic visits are not covered

4.3 Laboratory and X-Ray Services

For laboratory services $350 and under (of allowable charges)*:	No co-payment
For laboratory services above $350 (of allowable charges)**:	Co-insurance, 20% of allowed amount, after deductible
For X-ray services $350 and under (of allowable charges)*:	No co-payment
For X-ray services above $350 (of allowable charges)**:	Co-insurance, 20% of allowed amount, after deductible

Instead of by dollar amount, the Contractor may choose to group these diagnostic tests as Major** (corresponding to the above $350 co-pay category) and Minor *(corresponding to the $350 and under category) and have co-payment schedules reflecting those same categorizations. These groups shall be closely based on allowable charges for (1) those $350 and under and (2) over $350.

4.4 Prescription Drugs

For generic drugs on an approved list:	$15 co-payment per prescription
For brand name drugs on an approved list:	Co-insurance, 25% of allowed amount
For drugs not on an approved list:	Co-insurance, 50% of allowed amount

4.5 Vision Screening Services

$25 co-payment, limit of one exam every 12 months

4.6 Hearing Screening Services

$25 co-payment, limit of one exam every 12 months

4.7 Durable Medical Equipment and Supplies

Co-insurance, 20% of allowed amount after deductible

4.8 Mental Health Services

4.8.1 Inpatient and Outpatient Facility:

Co-insurance, 20% of allowed amount after deductible

4.8.2 Office Visit:

No co-payment

4.8.3 Residential Treatment:

Co-insurance, 50% of allowed amount after deductible, limit of 25 visits per plan year

4.9 Ambulance - Ground and Air

Co-insurance, 20% of allowed amount after deductible

4.10 Home Health and Hospice Care

Co-insurance, 20% of allowed amount after deductible

4.11 Deductible

Plan C enrollees are required to pay $500 per person / $1,500 per family.

4.12 Pre-existing Condition Waiting Period

No waiting period

4.13 Out-of-Pocket Maximum

The maximum out-of-pocket expense is 5% of the family's annual gross income.

If the out-of-pocket maximum exceeds 5% of the family's annual gross income, the family should contact the Department. Upon request, the Contractor will provide the Department with a record of co-insurance and co-payments that make up the family's out-of-pocket expenses. Upon notification from the Department, the Contractor will switch the family to a no out-of-pocket payment (exempt) option, will reimburse the family for any excess amount paid above 5%, and will mail new identification cards to the family.

NOTE: **The allowed amount is (1) the contract rate that the Contractor has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.**

SECTION 5: Requirements for CHIP Native American Policy

5.1 Hospital Services (inpatient, outpatient and emergency department)

No co-payment, plan pays 100%

Plan pays 100% for surgeon, anesthesiologist, ambulatory surgical, outpatient hospital, and hospital inpatient physician visits

5.2 Outpatient Office Visits or Urgent Care Center Visits

This includes physician, physician-related, physical and occupational therapy, urgent care, speech therapy, and podiatry visits.

No co-payment, plan pays 100%

No co-payment for immunizations and well child exams

20 visit combined limit per plan year on physical, occupational, and speech therapy

Chiropractic visits are not covered

5.3 Laboratory and X-Ray Services

Plan pays 100%

5.4 Prescription Drugs

No co-pay for prescriptions

5.5 Vision Screening Services

No co-payment, Plan pays 100%, limit of one exam every 12 months.

5.6 Hearing Screening Services

No co-payment, Plan pays 100%, limit of one exam every 12 months.

5.7 Durable Medical Equipment and Supplies

Plan pays 100%

5.8 Mental Health Services

5.8.1 Inpatient and Outpatient Facility:

Plan pays 100%

5.8.2 Office Visit:

Plan pays 100%

5.8.3 Residential Treatment:

Plan pays 100%, limit of 25 visits per plan year

5.9 Ambulance - Ground and Air

Plan pays 100%

5.10 Home Health and Hospice Care

Plan pays 100%

5.11 Pre-existing Condition Waiting Period

No waiting period

5.12 Out-of-Pocket Maximum

Not applicable. There are no out-of-pocket expenses for Native Americans.

NOTE: **The allowed amount is (1) the contract rate that the Contractor has with providers or (2) the lesser of billed charge less 25% or other negotiated rate for non-contracted providers, except for prescription drugs.**

SECTION6: Balance Billing

6.1 Balance Billing

No claim for payment, except for co-payments, deductibles, and co-insurance, will be made by the Contractor or Health Plan provider from the Enrollee for a service covered under the CHIP contract.

The Contractor and Health Plan provider will not balance bill the Enrollee. The Health Plan provider will consider the reimbursement from the Contractor plus co-payments, deductibles, and/or co-insurance as payment in full.

SECTION 7: Contract Year Basis for Benefits

7.1 Benefits – Contract Year Basis

Benefits are administered on a contract year basis. The Contractor is not responsible to administer run-in claims from the prior health plan. The 5% out-of-pocket maximum is calculated based on the date the Enrollees eligibility begins and the 5% maximum starts over at each recertification.

RATES AND RELATED PROVISIONS

1. Premium Rates

$110.87 PMPM – October 1, 2015 to December 31, 2015

$90.79 PMPM – January 1, 2016 to June 30, 2016

2. 100 % Risk Contract

This contract is a 100% risk contract for the Health Plan with no stop loss or savings/ loss sharing provisions. The Department shall pay the Health Plan the premium per member per month as described in section 1. The Health Plan shall bear complete responsibility and risk for all expenditures related to this contract, including but not limited to medical, pharmacy, administration, and any other costs. Accordingly, all savings or losses that result from the difference between premium reimbursements and expenditures shall be retained by the Health Plan.