Child Health Plus Benefits Package

No Pre-Existing Condition Limitations Permitted
No Co-payments or Deductibles
January 1, 2016

General Coverage	Scope of Coverage	Level of Coverage
Pediatric Health Promotion Visits	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the Advisory Committee on Immunization Practices recommended immunization schedule.	Includes all services related to visits. Includes immunizations which must be provided within 90 days from publication in the Morbidity and Mortality Weekly Report, well child care, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, eye screening, lead screening, and reproductive health services, with direct access to such reproductive health services.
Inpatient Hospital or Medical or Surgical Care	As a registered bed patient for treatment of an illness, injury or condition which cannot be treated on an outpatient basis. The hospital must be a short-term, acute care facility and New York State licensed.	No benefits will be provided for any out-of-hospital days, or if inpatient care was not necessary; no benefits are provided after discharge; benefits are paid in full for accommodations in a semi-private room. A private room will be covered if medically warranted. Includes 365 days per year coverage for inpatient hospital services and services provided by physicians and other professional personnel for covered inpatient services: bed and board, including special diet and nutritional therapy: general, special and critical care nursing services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care; oxygen and other inhalation therapeutic services and supplies; drugs and medications that are not experimental; sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies; blood products, except when participation in a volunteer blood replacement program is available to the insured or covered person, and services and equipment related to their administration; facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electro-encephalographic studies and examinations; facilities, services, supplies and equipment related to radiation and nuclear therapy; facilities, services, supplies and equipment related to emergency medical care; chemotherapy; any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the hospital.
Inpatient Mental Health and Alcohol and Substance Abuse Services	Services to be provided in a facility operated by OMH under sec. 7.17 of the Mental Hygiene Law, or a facility issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law or a general hospital as defined in Article 28 of the Public Health Law.	No limitations for inpatient mental health services, inpatient detoxification and inpatient rehabilitation.

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Inpatient Rehabilitatio	Acute care services provided by an Article 28 General Hospital	Services supplies and equipment related to physical medicine and occupational therapy and short-term rehabilitation.
Professional Services for Diagnosis and Treatment of Illness and Injury	Provides services on ambulatory basis by a covered provider for medically necessary diagnosis and treatment of sickness and injury and other conditions. Includes all services related to visits. Professional services are provided on outpatient basis and inpatient basis.	No limitations. Includes wound dressing and casts to immobilize fractures for the immediate treatment of the medical condition. Injections and medications provided at the time of the office visit or therapy will be covered. Includes audiometric testing where deemed medically necessary.
Hospice Services and Expenses	Coordinated hospice program of home and inpatient services which provide non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.	Hospice services include palliative and supportive care provided to a patient to meet the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Hospice organizations must be certified under Article 40 of the NYS Public Health Law. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements. All services must be provided according to a written plan of care which reflects the changing needs of the patient/family. Family members are eligible for up to five visits for bereavement counseling.
Outpatient Surgery	Procedure performed within the provider's office will be covered as well as "ambulatory surgery procedures" which may be performed in a hospital-based ambulatory surgery service or a freestanding ambulatory surgery center.	The utilization review process must ensure that the ambulatory surgery is appropriately provided.
Diagnostic and Laboratory Tests	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays.	No limitations.
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	Durable Medical Equipment means devices and equipment ordered by a practitioner for the treatment of a specific medical condition which: • Can withstand repeated use for a protracted period of time; • Are primarily and customarily used for medical purposes; • Are generally not useful in the absence of illness or injury; and • Are usually not fitted, designed or fashioned for a particular person's use. DME intended for use by one person may be custom-made or customized.	Includes hospital beds and accessories, oxygen and oxygen supplies, pressure pads, volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care, traction equipment, walkers, wheelchairs and accessories, commode chairs, toilet rails, apnea monitors, patient lifts, nutrition infusion pumps, ambulatory infusion pumps and other miscellaneous DME. DME coverage includes equipment servicing (labor and parts). Examples include, but are not limited to: Fitted/Customized leg brace — Not fitted/Customized cane Prosthetic arm — Wheelchair Footplate — Crutches

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	Prosthetic Appliances are those appliances and devices ordered by a qualified practitioner which replace any missing part of the body.	Covered without limitation except that there is no coverage for cranial prosthesis (*i.e.* wigs) and dental prosthesis, except those made necessary due to accidental injury to sound, natural teeth and provided within twelve months of the accident, and except for dental prosthesis needed in treatment of congenital abnormality or as part of reconstructive surgery.
	Orthotic Devises are those devices which are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.	No limitations on orthotic devices except that devices prescribed solely for use during sports are not covered.
Therapeutic Services	Ambulatory radiation therapy, chemotherapy, injections and medications provided at time of therapy (*i.e.* chemotherapy) will also be covered.	No limitations. These therapies must be medically necessary and under the supervision or referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. Physical and occupational therapies for a child diagnosed with an autism spectrum disorder are also covered when such treatment is deemed habilitative or nonrestorative. No procedure or services considered experimental will be reimbursed.
	Hemodialysis	Determination of the need for services and whether home-based or facility-based treatment is appropriate.
	Infusion of blood clotting factor and other services in connection with the treatment of blood clotting protein deficiencies	Coverage for blood clotting factor, supplies and other services needed for home infusion of blood clotting factor for the treatment of a blood clotting protein deficiency. Infusion may be performed in an outpatient setting or in the home by a home by a home health care agency, a properly trained parent or legal guardian of a child, or a properly trained child that is physically and developmentally capable of self-administering such products.
Speech and Hearing Services Including Hearing Aids	Hearing examinations to determine the need for corrective action and speech therapy performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.	One hearing examination per calendar year is covered. If an auditory deficiency requires additional hearing exams and follow-up exams, these exams will be covered. Hearing aids, including batteries and repairs, are covered. If medically necessary, more than one hearing aid will be covered. Covered speech therapy services are those required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day of therapy. Covered speech therapy services for a child diagnosed with an autism spectrum disorder shall also be provided if deemed habilitative or nonrestorative.
Pre-Surgical Testing	All tests (laboratory, x-ray, etc.) necessary prior to inpatient or outpatient surgery.	Benefits are available if a physician orders the tests: proper diagnosis and treatment require the tests; and the surgery takes place within seven days after the testing. If surgery is canceled because of pre-surgical test findings or as a result of a Second Opinion on Surgery, the cost of the tests will be covered.
Second Surgical Opinion	Provided by a qualified physician.	No limitations.
Second Medical	Provided by an appropriate specialist, including one affiliated with a specialty care center.	A second medical opinion is available in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment of cancer.

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Outpatient Visits for Mental Health and for the Diagnosis and Treatment of Alcoholism and Substance Abuse	Services must be provided by certified and/or licensed professionals.	No limitations. Visits may include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.
Home Health Care Services	The care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility would otherwise have been required if home care was not provided and the plan covering the home health service is established and provided in writing by such physician.	Home care shall be provided by a certified home health agency possessing a valid certificate of approval issued pursuant to Article 36 of the Public Health Law. Home care shall consist of one or more of the following: part-time or intermittent home health aide services which consist primarily of caring for the patient, physical, occupational, or speech therapy if provided by the home health agency and medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility. The contract must provide 40 such visits in any calendar year, if such visits are medically necessary.
Prescription and Non-Prescription Drugs	Prescription and non-prescription medications must be authorized by a professional licensed to write prescriptions.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. Includes family planning or contraceptive medications or devices. All medications used for preventive and therapeutic purposes will be covered. Vitamins are not covered except when necessary to treat a diagnosed illness or condition. Coverage includes enteral formulas for home use for which a physician or other provider authorized to prescribe has issued a written order. Enteral formulas for the treatment of specific diseases shall be distinguished from nutritional supplements taken electively. Coverage for certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
Emergency Medical Services	For services to treat an emergency condition in hospital facilities. For the purpose of this provision, "emergency • Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person.	No limitations.

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Ambulance Services	Pre-hospital emergency medical services, including prompt evaluation and treatment of an emergency condition and/or non-airborne transportation to a hospital.	Services must be provided by an ambulance service issued a certificate to operate pursuant to Section 3005 of the Public Health Law. Evaluation and treatment services must be for an emergency condition defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: • Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person. Coverage for non-airborne emergency transportation is based on whether a prudent layperson, possessing an average knowledge of medicine and health, could reasonable expect the absence of such transportation to result in: • Placing the health of the person afflicted with such condition in serious jeopardy; • Serious impairment to such person's bodily functions; • Serious dysfunction of any bodily organ or part of such person; or • Serious disfigurement of such person.
Maternity Care	Inpatient hospital coverage for at least 48 hours after childbirth for any delivery other than a C-Section and in at least 96 hours following a C-section. Also coverage of parent education, assistance and training in breast and bottle feeding and any necessary maternal and newborn clinical assessments. The mother shall have the option to be discharged earlier than the 48/96 hours, provided that at least one home care visit is covered post-discharge. Prenatal, labor and delivery is covered.	No limitations; (however subsidized children requiring maternity care services will be referred to Medicaid).
Diabetic Supplies and Equipment	Coverage includes insulin, blood glucose monitors, blood glucose monitors for visually impaired, data management systems, test strips for monitors and visual reading, urine test strips, insulin, injection aids, cartridges for visually impaired, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, oral agents.	As prescribed by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law.

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Ostomy Equipment and Supplies	Coverage includes ostomy equipment and supplies used to contain diverted urine or fecal contents outside the body from a surgically created opening (stoma).	As prescribed by a health care provider legally authorized to prescribe under title eight of the education law.
Diabetic Education and Home Visits	Diabetes self-management education (including diet); reeducation or refresher. Home visits for diabetic monitoring and/or education.	Limited to visits medically necessary where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management or where reeducation is necessary. May be provided by a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law, or their staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified diagnosis nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider legally authorized to prescribe under title eight of the education law and may be limited to group settings wherever practicable.
Emergency, Preventive and Routine Vision Care	Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to: • Case history • Internal and External examination of the eye • Opthalmoscopic exam • Determination of refractive status • Binocular balance • Tonometry tests for glaucoma • Gross visual fields and color vision testing • Summary findings and recommendations for corrective lenses
	Prescribed Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
	Contact Lenses	Covered when medically necessary.

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Diagnosis and Treatment of an Autism Spectrum Disorder	Coverage for the Screening, Diagnosis and Treatment of Autism Spectrum Disorders	Includes the following care and assistive communicative devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist: • Behavioral health treatment; • Psychiatric care; • Psychological care; • Medical care provided by a licensed health care provider; • Therapeutic care, including therapeutic care which is deemed habilitative or non-restorative; and • Pharmacy care. Applied behavioral analysis shall be covered. Assistive communication devices shall be covered when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means such as speech or in writing. Assistive communication devices such as communication boards and speech-generating devices may be rented or purchased, subject to prior approval. Coverage must include dedicated communication devices, which are devices that generally are not useful to a person in the absence of a communication impairment. Items such as laptops, desktops, or tablet computers are not covered items but software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device is a covered item.
Emergency, Preventive and Routine Dental Care	Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
	Preventive Dental Care	Includes procedures which help prevent oral disease from occurring, including but not limited to: • Prophylaxis: scaling and polishing the teeth at 6 month intervals • Topical fluoride application at 6 month intervals where local water supply is not fluoridated • Sealants on unrestored permanent molar teeth. • Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed detention to maintain space for normally developing permanent teeth.
	Routine Dental Care	• Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt) • X-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-12 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt) • All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care • In office conscious sedation • Amalgam, composite restorations and stainless steel crowns • Other restorative materials appropriate for children

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	Endodontics	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
	Prosthodontics	Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Fixed: Fixed bridges are not covered unless 1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; 2) Required for cleft-palate treatment or stabilization; 3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
		NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.
	Orthodontics	Prior approval for orthodontia coverage is required. Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/ mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if the child does not meet the criteria described above. Procedures include but are not limited to: • Rapid Palatal Expansion (RPE) • Placement of component parts (e.g. brackets, bands) • Interceptive orthodontic treatment • Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted) • Removable appliance therapy • Orthodontic retention (removal of appliances, construction and placement of retainers)

Child Health Plus Benefits Package Exclusions
January 1, 2016

The following services will NOT be covered:

- Experimental medical or surgical procedures.
- Experimental drugs.
- Drugs which can be bought without prescription, except as defined.
- Prescription drugs used for purposes of treating erectile dysfunction.
- Prescription drugs and biologicals and the administration of these drugs and biologicals that are furnished for the purpose of causing or assisting in causing the death, suicide, euthanasia or mercy killing of a person.
- Private duty nursing.
- Home health care, except as defined.
- Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.
- Services in a skilled nursing facility.
- Cosmetic, plastic, or reconstructive surgery, except as defined.
- In vitro fertilization, artificial insemination or other means of conception and infertility services.
- Services covered by another payment source.
- Durable Medical Equipment and Medical Supplies, except as defined.
- Transportation, except as defined.
- Personal or comfort items.
- Services which are not medically necessary.