SOURCE: THE NEW YORK STATE DEPARTMENT OF HEALTH'S REQUEST FOR F
for CHIP: September ll, l990

CHILD HEALTH INSURANCE PLAN MINIMUM
BENEFITS PACKAGE
(No Pre-existing Condition Limitations Permitted)

General Coverage	Scope of Coverage	Level of Coverage	Copay
Pediatric Health Promotion Visits.	Well child care visits in accordance with visitation schedule established by American Academy of Pediatrics, and the New York State Department of Health recommended immunization schedule.	Includes all services related to visits. Includes immunizations, well child care, health education, tuberculin testing (mantoux), hearing testing, dental and developmental screening, clinical laboratory and radiological tests, and eye screening.	No dec

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Outpatient visits for the diagnosis and treatment of alcoholism and substance abuse.	Services must be provided by certified and/or licensed professionals.	Provide at least 60 outpatient visits per year. A minimum of 20 of the 60 visits may be used for family therapy visits related to the alcohol abuse.	No dec
Prescription Drugs and Insulin.	Prescription medications must be authorized by a professional licensed to write prescriptions. The insurer may subcontract with a provider network for the provision of these services.	Prescriptions must be medically necessary. May be limited to generic medications where medically acceptable. All medications used for preventive and therapeutic purposes will be covered. Vitamin coverage need not be mandated except when necessary to treat a diagnosed illness or condition.	$1. pre wil for

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Diagnostic and Laboratory Tests.	Prescribed ambulatory clinical laboratory tests and diagnostic x-rays. The insurer may subcontract with a provider network for the provision of these services.	No limitations.	No ded
Therapeutic Services.	Ambulatory radiation therapy, chemotherapy, hemodialysis. 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 super-vision or referral of a licensed physician. Short term physical and occupational therapies will be covered when ordered by a physician. No procedure or service considered experimental will be reimbursed.	No ded

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General Coverage	Scope of Coverage	Level of Coverage	Copay
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.	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. "Outpatient surgery procedures 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.	No dec

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Emergency Medical Services	For sudden and unexpected illnesses and accidental injuries. The medical condition must be of such a nature that failure to render immediate care could reasonably result in deterioration where the patient's life would be in jeopardy or serious impairment to bodily functions would occur. Accidents must be treated within 72 hours of injury. Certified and licensed facilities must be used.	No limitations.	A $ may eme was dit not gui in cov cop wai med ava eme the sit cop is the not ins hou suc

CHILD HEALTH INSURANCE PLAN
OPTIONAL PRIMARY AND PREVENTIVE HEALTH CARE SERVICES

General Coverage	Scope of Coverage	Level of Coverage	Copay Deduc
DENTAL	Diagnostic Dentistry	o All eligible children within the family must enroll. Evaluation of existing conditions to determine what dental care is required. These include: o dental examinations, visits and consultations covered once within a 6 month consecutive period (when primary teeth erupt). o x-ray, full mouth x-rays at 36 month intervals, if necessary, bitewing x-rays at 6-l2 month intervals, or panoramic x-rays at 36 month intervals if necessary; and other x-rays as required (once primary teeth erupt). All eligible children within the family must enroll.	

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OPTIONAL PRIMARY AND PREVENTIVE HEALTH CARE SERVICES

General Coverage	Scope of Coverage	Level of Coverage	Copay Deduc
DENTAL	Oral Surgery	All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including: o preoperative care o postoperative care	
	Oral surgery/ general anesthesia and conscious sedation	In office conscious sedation not including nitrous oxide	
	Restorative Dentistry	Include all necessary procedures for o Amalgam, composite restorations and stainless steel crowns. o Other restorative materials appropriate for children will be covered.	
	Orthodontics	Limited to interceptive orthodontic therapy with removable applicances to correct: o deep overbite o anterior/posterior crossbites o palatal expansion o space maintenance for premature loss of primary teeth o destructive oral habits	

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OPTIONAL PRIMARY AND PREVENTIVE HEALTH CARE SERVICES

General Coverage	Scope of Coverage	Level of Coverage	Copay Deduc
DENTAL	Pediodontics	Includes all necessary procedures for providing treatment of gums and bones supporting teeth not requiring hospitalization.	
	Endodontics	Include all necessary procedures for treatment of diseased pulp chamber and pulp canals, and where hospitalization is not requried.	
	Prosthodontics	Provide minor interceptive on the uni and bi lat sm's. Includes medically necessary procedures for providing artifical replacement for missing teeth BR or PA: construction, placement and insertion of BR bridges, partial and complete dentures.	
	Emergency Treatment	Include emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.	

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General Coverage	Scope of Coverage	Level of Coverage	Copay Deduc
DENTAL	Preventive Dental Services	Include procedures which help prevent oral diseases from occurring, including but limited to: o Prophylaxis: scaling and polishing the teeth at 6 month intervals. o Topical application at 6 month intervals where local water supply is not fluoridated. o Sealants on unrestored permanent molar teeth.	

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HEARING	Hearing examinations authorized by the primary care physician to determine the need for corrective action.	An examination where performed by a licensed and certified physician and/or audiologist will be covered once in a l2 month consecutive period. Hearing aids will be covered when authorized or approved by a physician and/or audiologist. Hearing aids will be assessed on an annual basis.	

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SPEECH THERAPY	The services of a qualified audiologist, speech pathologist, speech therapist and/or otolaryngologist will be covered.	Services may include but not be limited to the following: o restoration of speech loss; or o correct an impairment due to a congenital defect for which corrective surgery has been performed, and due to and resulting from an accident or sickness. o correction of speech disorders due to manifestation of congenital disorder, developmental speech language delays, medical conditions associated with speech/language delays, neuro-motor disorder, language learning disabilities, attention deficit disorder, emotional disorder.	
		A minimum of 30 speech therapy sessions per year will be covered. Benefits up to an additional 20 visits per year will be provided if deemed medically necessary and as therapy proves beneficial.	

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General Coverage	Scope of Coverage	Level of Coverage	Copay Deduc
VISION	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 insurer may subcontract with a provider network for the provision of these services.	The vision examination may include, but is not limited to: o case history o external examination of the eye and external or internal examination of the eye. o ophthalmoscopic exam o determination of retroactive status o binocular balance o tonometry tests for glaucoma o gross visual fields and color vision testing o summary findings and recommendations for corrective lenses	
	Prescribed lenses	A minimum, quality standard prescription lenses by a physician, optometrist or optician are to be covered once in any consecutive l2 month period. The lenses may be glass or plastic lenses.	
VISION	Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any l2 consecutive month period.	

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EXCLUSIONS

The following services will not be covered:

- Inpatient hospitalization.
- Inpatient and outpatient psychiatric care.
- Inpatient preadmission testing.
- Mental health services.
- Durable medical equipment and prosthetics.
- Private duty nursing.
- Hospice services.
- Home health care.
- 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.
- Long term care services in a skilled nursing facility.