Exhibit 2

MISSISSIPPI CHILDREN'S HEALTH INSURANCE (CHIP) BENEFIT PLAN

UnitedHealthcare-Mississippi

Effective January 1, 2010

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NOTE: Members with Annual Family Income of less than or equal to 150% of the Federal Poverty Level

SCHEDULE OF BENEFITS
(Coverage Plan # MSCHP01)

BENEFIT PERIOD	CALENDAR YEAR BEGINNING JANUARY 1ST
LIFETIME MAXIMUM BENEFITS	No Lifetime Maximum Benefits
DEDUCTIBLE AMOUNTS	No Deductible Amount
OUT-OF-POCKET MAXIMUM (CO-PAY MAXIMUM)	No Out-of Pocket Maximum

COVERED SERVICES	BENEFIT	
	Network Provider	Non-Network Provider
HOSPITAL SERVICES		
Hospital Room and Board (Including Dietary and General Nursing Services)	100%	No Benefits
Other Services	100%	No Benefits
AMBULATORY SURGICAL FACILITY SERVICES SERVICES (ASF)	100%	No Benefits
EMERGENCY ROOM SERVICES	100%	See Below

Emergency Room Services - Benefits for emergency room services will be provided in cases of a Medical Emergency. When emergency room services of a Non-Network Provider are used by a Member for a Medical Emergency, the Network level of Benefits will be provided. However, if a Member uses emergency room services of a Non-Network Provider for a non-emergency situation, no Benefits will be provided to the Member.

	Network Provider	Non-Network Provider
PHYSICIAN SERVICES (M.D. and D.O. only) OR HEALTH CARE PROFESSIONALS		
Office Visits	100%	No Benefits
Other Services Rendered the Physician's Office	100%	No Benefits
Surgery (Hospital/ASF)	100%	No Benefits
Medical (Inpatient)	100%	No Benefits
Diagnostic Services	100%	No Benefits
Other Therapy Services (Includes Drug Therapy for chronic disease or condition)	100%	No Benefits
OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER, FACILITY OR PROFESSIONAL (WHERE APPLICABLE), OR PHYSICIAN (WHERE APPLICABLE)		
Ambulance Services	100%	100%
Durable Medical Equipment (Prior Authorization Required)	100%	No Benefits
Home Infusion Therapy (Prior Authorization Required)	100%	No Benefits
Orthotic/Prosthetic (Prior Authorization Required)	100%	100%
Hospice (Limited to a Lifetime Maximum of $15,000 per Member) (Prior Authorization Required)	100%	100%
Speech Therapy (Prior Authorization Required)	100%	100%
Occupational/Physical Therapy (Prior Authorization Required)	100%	100%
Manipulative Therapy (Limited to $2,000 per Member per Benefit Period)	100%	No Benefits
Private Duty Nursing (Limited to $10,000 per Member per Benefit Period) (Prior Authorization Required)	100%	100%

	Network Provider	Non-Network Provider
Skilled Nursing Services (Limited to 60 Days per Benefit Period)	100%	100%
Free-standing Diagnostic Facility	100%	No Benefits
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	100%	No Benefits
OUTPATIENT PRESCRIPTION DRUGS (Limited to a 30-day supply)		
Generic	100%	No Benefits
Brand	100%	No Benefit
NERVOUS AND MENTAL CARE		
Inpatient Care (Requires Prior Authorization)	100%	No Benefits
Partial Hospitalization	100%	No Benefits
Outpatient Hospital Visits	100%	No Benefits
Outpatient Professional Visits	100%	No Benefits

	Network Provider	Non-Network Provider
SUBSTANCE ABUSE CARE		
Inpatient Care (Prior Authorization Required)	100%	No Benefits
Outpatient Care	100%	No Benefits
Residential Substance Abuse Treatment	100%	100%
TRANSPLANT BENEFITS		
Heart, Lung, Liver, Kidney, Bone Marrow/Stem Cell (Prior Authorization Required)	100%	No Benefits
Transportation/Lodging Expenses (Limited to $10,000 per Member)	100%	Not Applicable
Living Donor Coverage includes searching for matching tissue, donor's transportation charges for removal and preservation and hospitalization. Living donor benefits are only available when the recipient (person receiving the organ) is a Member. See further details.	100%	No Benefits
TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER (TMJ)		
Surgery	100%	No Benefits
Diagnostic	100%	No Benefits
Surgery/Diagnostic Services for TMJ limited to $5,000 Lifetime Maximum Benefits (Prior authorization required)		
NEWBORN WELL BABY CARE	100%	No Benefits

	Network Provider	Non-Network Provider
DIABETES TREATMENT Self-Management Training/ Education and Medical Nutrition Therapy (Limited to $250 per Member per Benefit Period)	100%	No Benefits
WELL CHILD CARE	100%	No Benefits
FAMILY PLANNING SERVICES (Contraceptive Management, Health Screening, Health Education Counseling)	100%	No Benefits
FEMALE HEALTH SERVICES (Routine obstetric/gynecological services)	100%	No Benefits
MATERNITY/PRENATAL SERVICES (Limited to pregnant female members under age 19 who are deemed eligible by DHS)	100%	No Benefits
HEARING SERVICES (As limited in this Benefit Plan)	100%	100%
VISION SERVICES (As limited in this Benefit Plan)	100%	No Benefits
DENTAL SERVICES $1500 Calendar Year Max (As limited in this Benefit Plan)	100%	No Benefits
CHILDHOOD ROUTINE IMMUNIZATIONS Benefits will be provided only for the administration of the immunization. The vaccines will be provided by the Mississippi State Department of Health. No Benefits will be provided for the vaccine.	100%	No Benefits

NOTE: Flu Shots and tetanus booster are subject to regular benefits.

PRIOR AUTHORIZATION

Prior Authorization of Elective Inpatient Admissions	Required
Prior Authorization of Durable Medical Equipment (over $500 per item)	Required
Prior Authorization of Home Infusion Therapy	Required
Prior Authorization of Transplant Procedures	Required
Prior Authorization of Private Duty Nursing	Required
Prior Authorization of Inpatient/Residential Substance Abuse Benefits	Required
Prior Authorization of Hospice Care	Required
Prior Authorization of Prosthetics (over $500 per item)	Required
Prior Authorization of Orthotic Devices (over $500 per item)	Required
Prior Authorization of Speech Therapy	Required
Prior Authorization of Occupational Therapy	Required
Prior Authorization of Physical Therapy	Required
Prior Authorization of Inpatient/Partial/ Hospitalization-Nervous/Mental Benefits	Required
Prior Authorization of TMJ Benefits	Required
Prior Authorization of Diabetic Training/Education	Required

NOTE: Members with Annual Family Income of 151% through 175% of the Federal Poverty Level

SCHEDULE OF BENEFITS
(Coverage Plan # MSCHP02)

BENEFIT PERIOD	CALENDAR YEAR BEGINNING JANUARY 1ST
LIFETIME MAXIMUM BENEFITS	No Lifetime Maximum Benefits
DEDUCTIBLE AMOUNTS	No Deductible Amount
OUT-OF-POCKET MAXIMUM (CO-PAY MAXIMUM)	$800

COVERED SERVICES	BENEFIT	
	Network Provider	Non-Network Provider
HOSPITAL SERVICES		
Hospital Room and Board (Including Dietary and General Nursing Services)	100%	No Benefits
Other Services	100%	No Benefits
AMBULATORY SURGICAL FACILITY SERVICES (ASF)	100%	No Benefits
EMERGENCY ROOM SERVICES	100% after $15 Co-pay per visit	See Below

Emergency Room Services - Benefits for emergency room services will be provided in cases of a Medical Emergency. When emergency room services of a Non-Network Provider are used by a Member for a Medical Emergency, the Network level of Benefits will be provided. However, if a Member uses emergency room services of a Non-Network Provider for a non-emergency situation, no Benefits will be provided to the Member.

	Network Provider	Non-Network Provider
		No Benefits
PHYSICIAN SERVICES (M. D. and D. 0. only) OR HEALTH CARE PROFESSIONAL**		
Office Visits (Note: The Co-pay does not apply to any other services rendered in the physician's office or to office visits for routine well baby and well child care.)	100% after $5 Co-pay	
Other Services Rendered in the Physician's Office	100%	No Benefits
Surgery (Hospital/ASF)	100%	No Benefits
Medical (Inpatient)	100%	No Benefits
Diagnostic Services	100%	No Benefits
Other Therapy Services (Includes Drug Therapy for chronic disease or condition)	100%	No Benefits

**The office visit co-payment amount does not apply to Audiologist, Ophthalmologist, Optometrists if the office visit is in connection with Preventive/Wellness Services.

OTHER COVERED SERVICES, SUPPLIES OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER, FACILITY OR PROFESSIONAL (WHERE APPLICABLE), OR PHYSICIAN (WHERE APPLICABLE)		
Ambulance Services	100%	100%
Durable Medical Equipment (Prior Authorization Required)	100%	No Benefits
Home Infusion Therapy (Prior Authorization Required)	100%	No Benefits
Orthotic/Prosthetic (Prior Authorization Required)	100%	100%

	Network Provider	Non-Network Provider
Hospice (Limited to a Lifetime Maximum of $15,000 per Member) (Prior Authorization Required)	100%	100%
Speech Therapy (Prior Authorization Required)	100%	100%
Occupational/Physical Therapy (Prior Authorization Required)	100%	100%
Manipulative Therapy (Limited to $2,000 per Member per Benefit Period)	100%	No Benefits
Private Duty Nursing (Limited to $10,000 per Member per Benefit Period) (Prior Authorization Required)	100%	100%
Skilled Nursing Services (Limited to 60 Days per Benefit Period)	100%	100%
Free-standing Diagnostic Facility	100%	No Benefits
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	100%	No Benefits
OUTPATIENT PRESCRIPTION DRUGS (Limited to a 30-day supply)		
Generic	100%	No Benefits
Brand	100%	No Benefits
NERVOUS AND MENTAL CARE		
Inpatient Care (Prior Authorization Required)	100%	No Benefits
Partial Hospitalization	100%	No Benefits
Outpatient Hospital Visits	100%	No Benefits
Outpatient Professional Visits	100%	No Benefits

	Network Provider	Non-Network Provider
SUBSTANCE ABUSE CARE		
Inpatient Care (Prior Authorization Required)	100%	No Benefits
Outpatient Care	100%	No Benefits
Residential Substance Abuse Treatment	100%	100%
TRANSPLANT BENEFITS		
Heart, Lung, Liver, Kidney, Bone Marrow/Stem Cell (Prior Authorization Required)	100%	No Benefits
Transportation/Lodging Expenses (Limited to $10,000 per Member)	100%	Not applicable
Living Donor Coverage includes searching for matching tissue, donor's transportation charges for removal and preservation and hospitalization. Living donor benefits are only available when recipient (person receiving the organ) is a Member. See further details.	100%	No Benefits
TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER (TMJ)		
Surgery	100%	No Benefits
Diagnostic	100%	No Benefits
Surgery/Diagnostic Services for TMJ limited to $5,000 Lifetime Maximum Benefits (Prior authorization required)		
NEWBORN WELL BABY CARE	100%	No Benefits

	Network Provider	Non-Network Provider
DIABETES TREATMENT Self-Management Training/ Education and Medical Nutrition Therapy (Limited to $250 per Member per Benefit Period)	100%	No Benefits
WELL CHILD CARE	100%	No Benefits
FAMILY PLANNING SERVICES (Contraceptive Management, Health Screening, Health Education Counseling)	100%	No Benefits
FEMALE HEALTH SERVICES (Routine obstetric/gynecological services)	100%	No Benefits
MATERNITY/PRENATAL SERVICES (Limited to pregnant female members under age 19 who are deemed eligible by DHS)	100%	No Benefits
HEARING SERVICES (As limited in this Benefit Plan)	100%	100%
VISION SERVICES (As limited in this Benefit Plan)	100%	No Benefits
DENTAL SERVICES $1500 Calendar Year Maximum (As limited in this Benefit Plan)	100%	No Benefits
CHILDHOOD ROUTINE IMMUNIZATIONS Benefits will be provided only for the administration of the immunization. The vaccines will be provided by the Mississippi State Department of Health. No Benefits will be provided for the vaccine.	100%	No Benefits

NOTE: Flu Shots and tetanus booster are subject to regular benefits.

PRIOR AUTHORIZATION

Prior Authorization of Elective Inpatient Admissions	Required
Prior Authorization of Durable Medical Equipment (over $500 per item)	Required
Prior Authorization of Home Infusion Therapy	Required
Prior Authorization of Transplant Procedures	Required
Prior Authorization of Private Duty Nursing	Required
Prior authorization of Inpatient/Residential Substance Abuse Benefits	Required
Prior Authorization of Hospice Care	Required
Prior Authorization of Prosthetics (Over $500 per item)	Required
Prior Authorization of Orthotic Devices (Over $500 per item)	Required
Prior authorization of Speech Therapy	Required
Prior Authorization of Occupational Therapy	Required
Prior Authorization of Physical Therapy	Required
Prior Authorization of Inpatient/Partial Hospitalization Nervous/Mental Benefits	Required
Prior authorization of TMJ Benefits	Required
Prior authorization of Diabetic Training/Education	Required

NOTE: Members with Annual Family Income 176% up through 200% of the Federal Poverty Level

SCHEDULE OF BENEFITS
(Coverage Plan MSCHP03)

BENEFIT PERIOD	CALENDAR YEAR BEGINNING JANUARY 1ST
LIFETIME MAXIMUM BENEFITS	No Lifetime Maximum Benefits
DEDUCTIBLE AMOUNTS	No Deductible Amount
OUT-OF-POCKET MAXIMUM (CO-PAY MAXIMUM)	$950

COVERED SERVICES	BENEFIT	
	Network Provider	Non-Network Provider
HOSPITAL SERVICES		
Hospital Room and Board (Including Dietary and General Nursing Services)	100%	No Benefits
Other Services	100%	No Benefits
AMBULATORY SURGICAL FACILITY SERVICES (ASF)	100%	No Benefits
EMERGENCY ROOM SERVICES	100% after $15 Co-pay per visit	See Below

Emergency Room Services - Benefits for emergency room services will be provided in cases of a Medical Emergency. When emergency room services of a Non-Network Provider are used by a Member for a Medical Emergency, the Network level of Benefits will be provided. However, if a Member uses emergency room services of a Non-Network Provider for a non-emergency situation, no Benefits will be provided to the Member.

	Network Provider	Non-Network Provider
PHYSICIAN SERVICES M.D. and D.O.only) OR HEALTH CARE PROFESSIONAL** Office Visits (Note: The Co-pay does not apply to any other Services rendered in the Physician's Office or to office visits for routine well baby and well child care.)	100% after $5 Co-pay	No Benefits
**The office visit co-payment amount does not apply to Audiologist, Ophthalmologist, Optometrists if the office visit is in connection with Preventive/Wellness Services		
Other Services Rendered	100%	No Benefits
Surgery (Hospital/ASF)	100%	No Benefits
Medical (Inpatient)	100%	No Benefits
Diagnostic Services	100%	No Benefits
Other Therapy Services (Includes Drug Therapy for chronic disease or condition)	100%	No Benefits
OTHER COVERED SERVICES, OR EQUIPMENT PROVIDED BY AN ALLIED PROVIDER, FACILITY OR PROFESSIONAL (WHERE APPLICABLE, OR PHYSICIAN (WHERE APPLICABLE)		
Ambulance Services	100%	100%
Durable Medical Equipment (Prior Authorization Required)	100%	No Benefits
Home Infusion Therapy (Prior Authorization Required)	100%	No Benefits
Orthotic/Prosthetic (Prior Authorization Required)	100%	100%
Hospice (Limited to a Lifetime Maximum of $15,000 per Member) (Prior Authorization Required)	100%	100%

	Network Provider	Non-Network Provider
Speech Therapy (Prior Authorization Required)	100%	100%
Occupational/Physical Therapy (Prior Authorization Required)	100%	100%
Manipulative Therapy (Limited to $2,000 per Member per Benefit Period)	100%	No Benefits
Private Duty Nursing (Limited to $10,000 per Member per Benefit Period) (Prior Authorization Required)	100%	100%
Skilled Nursing Services (Limited to 60 Days per Benefit Period)	100%	100%
Free-standing Diagnostic Facility	100%	No Benefits
Other Therapy Services (Radiation, Chemotherapy, Dialysis, Drug, Infusion)	100%	No Benefits
OUTPATIENT PRESCRIPTION DRUGS (Limited to a 30-day supply)		
Generic	100%	No Benefits
Brand	100%	No Benefits
NERVOUS AND MENTAL CARE		
Inpatient Care	100%	No Benefiits
Partial Hospitalization	100%	No Benefits
Outpatient Hospital Visits	100%	No Benefits

	Network Provider	Non-Network Provider
Outpatient Professional Visits	100%	No Benefits

Note: For the purposes of the office visit co-pay, Licensed Professional Counselors and Licensed Clinical Social Workers are considered Network Providers.

SUBSTANCE ABUSE CARE

Inpatient Care (Prior Authorization Required)	100%	No Benefits
Outpatient Care (Office Visits will be subject to the Physician/Health Care Professional Office Co-pay when provided by the appropriate Provider.)	100%	No Benefits
Residential Substance Abuse Treatment	100%	100%

TRANSPLANT BENEFITS

Heart, Lung, Liver, Renal, Bone Marrow/Stem Cell	100%	No Benefits
Transportation/Lodging Expenses (Limited to $10,000 per Member)	100%	Not Applicable
Living Donor Coverage includes searching for matching tissue, donors transportation charges for removal and preservation and hospitalization. Living donor benefits are only available when the recipient (person receiving the organ) is a Member. See further details.	100%	No Benefits

	Network Provider	Non-Network Provider
TEMPOROMANDIBULAR/CRANIOMANDIBULAR JOINT DISORDER (TMJ)		No Benefits
Surgery	100%	
Diagnostic	100%	No Benefits
Surgery/Diagnostic Services for TMJ limited to $5,000 Lifetime Maximum Benefits (Prior authorization required)		
NEWBORN WELL BABY CARE	100%	No Benefits
DIABETES TREATMENT Self-Management Training/ Education and Medical Nutrition Therapy (Limited to $250 per Member per Benefit Period)	100%	No Benefits
WELL CHILD CARE	100%	No Benefits
FAMILY PLANNING SERVICES (Contraceptive Management, Health Screening, Health Education Counseling)	100%	No Benefits
FEMALE HEALTH SERVICE (Routine obstetric/gynecological services)	100%	No Benefits
MATERNITY/PRENATAL SERVICES (Limited to pregnant female members under age 19 who are deemed eligible by DHS.)	100%	No Benefits
HEARING SERVICES As limited in this Benefit Plan	100%	100%

	Network Provider	Non-Network Provider
VISION SERVICES (As limited in this Benefit Plan)	100%	No Benefits
DENTAL SERVICES $1500 Calendar Year Maximum (As limited in this Benefit Plan)	100%	No Benefits
CHILDHOOD ROUTINE IMMUNIZATIONS Benefits will be provided only for the administration of the immunization. The vaccines will be provided by the Mississippi State Department of Health. No Benefits will be provided for the vaccine.	100%	No Benefits

NOTE: Flu Shots and tetanus booster are subject to regular benefits.

PRIOR AUTHORIZATION

Prior Authorization of Elective Inpatient Admissions	Required
Prior Authorization of Durable Medical Equipment (Over $500 per item)	Required
Prior Authorization of Home Infusion Therapy	Required
Prior Authorization of Transplant Procedures	Required
Prior Authorization of Private Duty Nursing	Required
Prior Authorization of Inpatient/Residential Substance Abuse Benefits	Required
Prior Authorization of Hospice Care	Required
Prior Authorization of Prosthetics (Over $500 per item)	Required
Prior Authorization of Orthotic Devices (Over $500 per item)	Required
Prior Authorization of Speech Therapy	Required
Prior Authorization of Occupational Therapy	Required
Prior Authorization of Physical Therapy	Required
Prior Authorization of Inpatient/Partial Hospitalization Nervous/Mental Benefits	Required
Prior Authorization of TMJ Benefits	Required
Prior Authorization of Diabetic Training/Education	Required

ARTICLE 1
DEFINITIONS

1.1 **Accidental Injury** – traumatic bodily injury sustained solely through accidental means where treatment commences within ten (10) days after the date of such injury. Injury to teeth as a result of chewing or biting will not be considered an Accidental Injury.

1.2 **Acute Care** – short-term diagnostic and therapeutic services rendered in a Hospital for an Enrolled Child who is ill from a disease of an acute nature or an injury of an acute nature. The period of Acute Care continues until the Enrolled Child is stable enough to be transferred to a long-term facility for rehabilitation or maintenance care, or until the Enrolled Child can be discharged to home care.

1.3 **Allowable Charge** – the lesser of the submitted charge or the amount established by the Health Plan, as provided through Provider Network contracts or based on an analysis of provider charges, as the maximum amount for all such provider services covered under the terms of this document.

1.4 **Ambulatory Surgical Facility** – an institution licensed as such by the appropriate state agency whose primary purpose is performing elective surgical procedures on an outpatient basis or an institution certified by Medicare as an Ambulatory Surgical Facility.

1.5 **Benchmark Plan** – The State and School Employees' Health Insurance Plan.

1.6 **Benefit Period** – a period of one calendar year commencing each January 1.

1.7 **Benefit Period Deductible** – the amount of Covered Expense defined by the Board that must be paid by the Enrolled Child before co-insurance is applied.

1.8 **Board** – The State and School Employees' Health Insurance Management Board created under Section 25-15-303 of the Mississippi Code.

1.9 **Child** – an individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance.

1.10 **CHIP** – The Children's Health Insurance Program as defined in Title XXI of the Social Security Act. (Refer also to Program.)

1.11 **Co-Payment** – a flat fee that an Enrolled Child may pay for Covered Health Services.

1.12 **Covered Health Care Service** – those health care services to which an Enrolled Child is entitled under the terms of these rules and regulations.

1.13 **Covered Provider** – Health Care Professionals and Facilities providing services within the scope of their licenses under state law and recognized under these rules and regulations to deliver Covered Health Care Services to Enrolled Children.

1.14 **Creditable Coverage** – prior health insurance coverage as defined under Section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)). Creditable Coverage includes coverage under group or individual health plans or health insurance, Medicare, Medicaid, other governmental plans, and state health benefit risk pools.

1.15 **Division of Medicaid** – the state agency authorized by state law to administer Medicaid.

1.16 **Durable Medical Equipment** – equipment prescribed by the attending physician and determined by the Health Plan to be Medically Necessary for treatment of an illness or injury, or to prevent the Enrolled Child's further deterioration. To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose rather than for comfort or convenience; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the Enrolled Child's home.

1.17 **Eligible Child(ren)** – a low-income child who meets all eligibility criteria for enrollment in the Program.

1.18 **Enrolled Child(ren)** – an eligible child who has been enrolled for coverage with the Health Plan under the Program. Where the parent/guardian is the responsible party for the Enrolled Child, references to the Enrolled Child are intended to include the parent/guardian.

1.19 **Facility** – a hospital or other entity licensed by the state as a specific type of institution to provide a specific level of care. For the purposes of payment as a facility, an entity must be licensed or certified as such by the appropriate state or federal agency, as approved by the Board.

1.20 **Health Care Professional** – a Practitioner or other medical provider who is licensed to perform specified health services consistent with state law. Health Care Professionals include physicians, nurse practitioners, dentists, optometrists, chiropractors, podiatrists, chiropodists, physical therapists, occupational therapists, audiologists, speech pathologists, psychologists, professional counselors, and clinical social workers.

1.21 **Health Plan or Plan** – the entity with whom the Board has contracted to insure, administer, deliver, arrange for, and reimburse the costs of Covered Health Services for Enrolled Children.

1.22 **Home Infusion Therapy** – services and Supplies required for the administration of a Home Infusion Therapy regimen. These services and Supplies must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Practitioner; (3) capable of safe administration in the home, as determined by the Health Plan; (4) provided by a licensed Home Infusion Therapy provider; (5) coordinated and approved by the Health Plan; (6) ordinarily in lieu of inpatient Hospital therapy; and (7) more cost effective than inpatient therapy.

1.23 **Hospital** – an institution which is primarily engaged in providing diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of physicians who are duly licensed to practice medicine in the state where the institution is located; which continuously provides twenty-four hour a day nursing service by a Registered Nurse (R.N.); and which is duly licensed as a Hospital in such state. The term Hospital may also include an institution that primarily provides psychiatric or chemical dependency care, if licensed as such by the state in which the Hospital is located.

1.24 **Intensified Outpatient Program** – as provided for the treatment of substance abuse, Intensive Outpatient Program refers to a program provided as a continuation of inpatient substance abuse treatment prescribed by a Health Care Professional, under the management of a licensed substance abuse provider.

1.25 **Investigative or Experimental/Investigative** – use of a procedure, facility, equipment, drug, device, or Supply not recognized at the time of treatment as accepted medical practice within the United States for the condition being treated. "Accepted Medical Practice" shall be determined by the advisory/governing bodies of medical practice in the U.S. including, but not limited to, the American Medical Association, the American Dental Association, and the Food and Drug Administration.

1.26 **Low Income Child** – a child whose family income does not exceed two hundred percent (200%) of the federal poverty level.

1.27 **Manipulative Therapy** – all services preparatory to or complimentary to an adjustment of the articulations of the vertebral column and its immediate articulations.

1.28 **Medicaid** – the federal/state program established under Title XIX of the Social Security Act, as amended, which provides federal matching funds for a medical assistance program for eligible recipients.

1.29 **Medical Emergency** – the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in: (1) permanently

placing the patient's health in jeopardy; (2) serious impairment of bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences. Determination of a Medical Emergency shall be based on presenting symptoms rather than final diagnosis.

1.30 **Medically Necessary** – Prescription Drugs, Health Care Services or Supplies required to identify or treat the illness or injury, which a Health Care Professional has diagnosed or reasonably suspects. The Prescription Drugs, Health Care Services or Supplies must be (1) consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (2) in accordance with the standards of good medical practice found in established managed care environments; (3) required for reasons other than the convenience of the patient or his Health Care Professional; (4) the most appropriate Prescription Drug, Supply or level of service which can be safely and efficiently provided to the patient. When applied to the care of an inpatient, it further means that the patient's medical symptoms or condition require that the services cannot safely be provided to the patient as an outpatient. For purposes of coverage under this Plan, the fact that a Health Care Professional has prescribed, ordered, recommended, or approved a Prescription Drug, Health Care Service or Supply does not in itself, make it Medically Necessary. (Refer also to "Investigative" in this Article).

1.31 **Medical Supplies or Supplies** – Supplies provided which are Medically Necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a patient to effectively carry out a Practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use by the patient.

1.32 **Network or Provider Network** – a defined group of Covered Providers recognized by the Health Plan to receive payment for Covered Health Care Services for Enrolled Children.

1.33 **Non-Participating Provider** – a Covered Provider who has not contracted with the Health Plan to deliver Covered Health Care Services to Enrolled Children.

1.34 **Orthotic Device** – an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

1.35 **Out-of-Pocket Maximum** – the aggregate amount of cost sharing (deductibles, co-insurance, and co-payments) incurred by all Enrolled Children in a single family in a Benefit Period. Once the Out-of-Pocket Maximum has been met, Covered Expenses are paid at 100% of the Allowable Charge for the remainder of the Benefit Period.

1.36 **Participating or Network Provider** – a Covered Provider recognized by the Health Plan to receive payment for the delivery of Covered Health Care Services to Enrolled Children.

1.37 **Partial Hospitalization** – inpatient treatment, other than full twenty-four-hour programs, in a treatment facility licensed or certified by the state in which services are rendered. This term includes day, night, and weekend treatment programs.

1.38 **Practitioner** – a physician, dentist, or other Health Care Professional authorized by law to diagnose and prescribe drugs.

1.39 **Pre-Existing Condition** – any condition, as defined by the Health Insurance Portability and Accountability Act, for which an Employer-Sponsored Insurance plan has denied coverage because of its existence prior to coverage under that plan.

1.40 **Prescription Drug** – drugs, including generic drugs and brand name drugs, that under federal law may be dispensed only by written prescription and which are approved for general use by the United States Food and Drug Administration. Prescription Drugs must be dispensed by a licensed pharmacist upon the prescription of a Practitioner as defined by law, must be Medically Necessary, and not Experimental/Investigative in order to be covered under the Program.

1.41 **Program** – Mississippi's Children's Health Insurance Program as authorized by Title XXI of the Social Security Act and Section 41-86-1 et seq. of the Mississippi Code.

1.42 **Prosthetic Device** – an artificial device which replaces all or part of an absent body part, or replaces all or part of the function of a permanently inoperable or malfunctioning body part.

1.43 **Provider** – a Health Care Professional or Facility licensed or certified to provide services within the scope of their license or certification under state law.

1.44 **Rehabilitative Care** – the coordinated use of medical, social, educational, or vocational services, beyond the acute care stage of disease or injury, or the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

1.45 **Skilled Nursing Facility** – a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to patients who require medical or nursing care that rehabilitates injured, disabled or sick patients, and that meets all of the following requirements.

1. Is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility;

2. Is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Practitioner;

3. Provides services under the supervision of physicians;

4. Provides nursing services by or under the supervision of a licensed registered nurse, with one licensed registered nurse on duty at all times;

5. Maintains a daily medical record of each patient who is under the care of a licensed physician;

6. Is not (other than incidentally) a home maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis facility; and

7. Is not a hotel or motel.

1.46 **Urgent Care** – care necessary for an acute condition, not as serious as an emergency, yet one in which medical necessity dictates early treatment, including that which can be provided in a hospital environment.

1.47 **Utilization Management** – a formal set of techniques designed to assess the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or setting given or proposed for an Enrolled Child, including consultation with the Enrolled Child or his/her family. Utilization management also refers to assisting Enrolled Children in obtaining and utilizing covered medical services where appropriate and when requested. Techniques may include, but are not limited to, pre-certification, concurrent review with discharge planning, case management, or retrospective review.

ARTICLE 2
ELIGIBILITY

2.1 Eligibility Determination

Eligibility for CHIP will be determined by the Division of Medicaid according to rules approved by the Division of Medicaid. Application will be made on the same form as that is used to apply for Medicaid.

2.2 Eligible Child

A. An Eligible Child is defined as a Low-Income Child who meets the following criteria:
   1. Is a Mississippi resident with intent to stay;
   2. Does not have creditable health coverage at the time of application;
   3. Is not eligible for Medicaid;
   4. Is not an inmate of a public institution or a patient in an institution for mental diseases.

B. Eligibility may not be denied on the basis of health status or medical history.

C. A newborn child for whom an application for CHIP is made within 31 days of birth will not be subject to review of creditable coverage.

2.3 Contributions

There is no enrollment fee or premium required for Eligible Children to be enrolled in the Program.

2.4 Coverage Levels

Eligible Children will have primary coverage under the Program through the Health Plan.

2.5 Enrollment Periods

Application for the Program can be made at any time. There are no special enrollment periods.

2.6 Effective Date of Coverage

For children whose eligibility information is transmitted to the Health Plan on or before the third (3rd) day of the current month, the effective date of coverage under the Benefit Plan will be the first day that month.

After the third day (3rd) day of the current benefit month (or previous business day following a state holiday or weekend), children whose eligibility is transmitted to the Health Plan will have an effective date under the Benefit Plan of the first day of the month following the month in which eligibility was transmitted.

There are two (2) exceptions to the preceding rules. For newborn children applying for coverage within 31 days of the date of birth, the effective date of coverage will be the date of birth. Children whose coverage was denied or terminated due to agency error will be accepted by the Health Plan retroactive to the first (1st) of the appropriate coverage month. Such additions will be limited to incidences of agency error for which there is no other legal means to provide coverage due the child.

2.7 Duration of Eligibility

A. Eligibility is effective for twelve months from the date of coverage or until one of the following events occurs:
   1. the Child becomes eligible for Medicaid;
   2. the Child no longer resides in Mississippi;
   3. the Child dies;
   4. the Child turns nineteen (19) years of age; or
   5. the Child becomes covered under other creditable coverage.

B. The Division of Medicaid shall determine the date of termination of eligibility.

2.8 Duration of Coverage

Coverage under CHIP shall terminate as of the end of the month in which eligibility terminated.

ARTICLE 3
BENEFITS PROVIDED

3.1 Cost Sharing

A. Deductible – No deductible amount is required under this Program.

B. Co-insurance – No co-insurance is required under this Program.

C. Co-payments

1. No co-payments may be charged for immunizations, well baby and well child care, preventive dental services, routine dental fillings, vision screening, hearing screening, eyeglasses, and hearing aids.

2. No co-payments are to be charged to Enrolled Children in families with an annual income up through 150 percent of the Federal Poverty Level.

3. No co-payments are to be charged to Enrolled Children of American Indian/Alaskan Native descent.

4. Enrolled Children in families with an annual income from 151 percent up through 200 percent of the Federal Poverty Level shall be responsible for the following co-payment amounts:

5.

Service	Co-payment
Outpatient Health Care Professional Visit	$5.00
Emergency Room Visit	15.00

D. Out-of-Pocket Maximum

1. The Out-of-Pocket Maximum amounts shall apply to all covered members of a family, as identified by the Division of Medicaid.

2. Families with an annual income from 151 percent up through 175 percent of the Federal Poverty Level shall have an Out-of-Pocket Maximum of $800.

3. Families with an annual income from 176 percent up through 200 percent of the Federal Poverty Level shall have an Out-of-Pocket Maximum of $950.

4. Once the family's co-payment amounts total to the Out-of-Pocket Maximum, the family will no longer be required to pay co-payments for the remainder of the Benefit Period.

3.2 Lifetime Maximum Benefit

There is no limit on the lifetime benefit available to Enrolled Children under the Program.

3.3 Covered Benefits

The following Covered Benefits will be provided subject to the terms and conditions of this Article and the Limitations and Exclusions set forth in this summary.

A. Inpatient Services

Inpatient services must be prior authorized as medically necessary and include the following:

(1) Hospital room and board (including dietary and general nursing services).
(2) Use of operating or treatment rooms.
(3) Anesthetics and their administration.
(4) Intravenous injections and solutions.
(5) Physical therapy.
(6) Radiation therapy.
(7) Oxygen and its administration.
(8) Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms.
(9) Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs.
(10) Dressings and Supplies, sterile trays, casts, and orthopedic splints.
(11) Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and Supplies.
(12) Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations.
(13) Intensive, Coronary, and Burn Care Unit services.
(14) Occupational therapy.
(15) Speech therapy.

B. **Medical services**

Medical services include the following:

(1) In-hospital medical care.
(2) Medical care in the Practitioner's office, Enrolled Child's home, or elsewhere.
(3) Surgery.
(4) Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Enrolled Child is covered under the Program. Injury to teeth as a result of chewing or biting is not considered an Accidental Injury. Covered medical expense must be incurred as a direct result of an accidental injury to natural teeth and medical treatment must begin within ten days of the accidental injury.
(5) Administration of anesthesia.
(6) Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests.
(7) Radiation therapy.
(8) Consultations.
(9) Psychiatric and psychological service for nervous and mental conditions.
(10) Physicians assisting in surgery, where appropriate.
(11) Emergency care or surgical services rendered in a Practitioner's office including but not limited to surgical and Medical Supplies, dressings, casts, anesthetic, tetanus serum and x-rays.
(12) Well child assessments, vision screening, hearing screening, and laboratory tests according to the American Academy of Pediatrics' recommendations for preventive pediatric health care. Vision and hearing screening are to be included as part of the periodic well child assessments.
(13) Routine Immunizations (according to ACIP guidelines) – Vaccine will be purchased and distributed through the State Department of Health. The Health Plan will reimburse providers for the administration of the vaccine.

C. **Surgical services**

Certain surgeries may be prior authorized as medically necessary. Benefits are provided for the following covered medical expenses furnished to the Enrolled Child by an Ambulatory Surgical Facility:

(1) Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure.
(2) Pre-operative preparation.

(3) Use of facility (operating rooms, recovery rooms, and all surgical equipment).
(4) Anesthesia, drugs and surgical Supplies.

D. **Clinic Services**

Clinic services (including health center services) and other ambulatory health care services are covered as medical services.

E. **Prescription drugs**

Health Plan pays for many prescription drugs. These drugs are listed in the preferred drug list (PDL). The Member can call member services for a list of our PDL drugs. This list can change, so it is important that the Members check this list each time the Member needs a prescription.

Generic drugs work the same way as the brand-name versions. If possible, the generic drug will be used. Health Plan will pay for brand name drugs that have a generic available when they are medically necessary and when the Member's doctor requires the prescription be filled as written. Some PDL drugs and all non-PDL drugs need a prior authorization. The Member's doctor will need to tell the Health Plan why the Member needs a specific drug or certain amount of a drug. The Health Plan must approve the request before the Member can get the drug. Health Plan will make a decision within 24 hours once the Health Plan receives all the information. In most cases, the Health Plan will grant a 5-day supply of the medication for the Member until the Health Plan processes the authorization request. If the Health Plan does not approve the request, the Health Plan will tell the Member how to appeal.

(1) The following drugs and medical supplies are covered:

(a) Legend drugs (federal law requires these drugs be dispensed by prescription only)
(b) Compounded medications of which at least one ingredient is a legend drug
(c) Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-tape)
(d) Disposable insulin needles/syringes
(e) Growth hormones
(f) Insulin
(g) Lancets
(h) Legend contraceptives
(i) Retin-A (tretinoin topical)
(j) Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets)

(k) Vitamin and mineral supplements, when prescribed as replacement therapy
(l) Legend pre-natal vitamins

(2) The following are excluded:

(a) Anabolic steroids (e.g., Winstrol, Durabolin)
(b) Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder
(c) Anti-wrinkle agents (e.g., Renova)
(d) Charges for the administration or injection of any drug
(e) Dietary supplements
(f) Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi)
(g) Minerals (e.g., Phoslo, Potaba)
(h) Medications for the treatment of alopecia, e.g. Minoxidil (Rogaine)
(i) Non-legend drugs other than those listed as covered
(j) Pigmenting/depigmenting agents
(k) Drugs used for cosmetic purposes
(l) Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorrette, Nicoderm, etc.)
(m) Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes
(n) Any medication not proven effective in general medical practice
(o) Investigative drugs and drugs used other than for the FDA approved diagnosis
(p) Drugs that do not require a written prescription
(q) Prescription Drugs if an equivalent product is available over the counter
(r) Refills in excess of the number specified by the Practitioner or any refills dispensed more than one year after the date of Practitioner's original prescription

F. Over-the-counter medications

Over-the-counter medications are not covered under the Program.

G. Laboratory and radiological services

Medically Necessary laboratory and radiological services are covered, but certain diagnostic tests must be pre-certified, as determined by the Board or the Health Plan.

H. **Prenatal care and pre-pregnancy family planning services and Supplies**

Infertility services are excluded.

I. **Mental Health Services**

(1) Inpatient mental health services, other than services described under substance abuse services, but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services.

(a) Benefits for Covered Medical Expenses are paid for medically necessary inpatient psychiatric treatment of an Enrolled Child.
(b) Benefits for covered medical expenses are provided for Partial Hospitalization.
(c) Certification of medical necessity by the Utilization Management Program is required for admissions to a hospital.
(d) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.

(2) Outpatient mental health services, other than services described under substance abuse services.

(a) Benefits for Covered Medical Expenses for treatment of nervous and mental conditions on an outpatient basis.
(b) Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.

J. **Durable medical equipment and other medically-related or remedial devices** (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)

(1) Rental of Durable Medical Equipment is covered for temporary therapeutic use; provided, however, at the Health Plan's discretion, the purchase price of such equipment may be allowed.
(2) To be Durable Medical Equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the Enrolled Child's home.
(3) Prosthetic or Orthotic Devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or

congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of Prosthetic or Orthotic devices that require a prescription by a physician and for the repair or replacement when Medically Necessary. Shoes are not covered except for the following: (1) a surgical boot which is part of an upright brace; (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes; and (3) a custom fabricated shoe in the case of a significant foot deformity.

(4) Eyeglasses are limited to one per year.

(5) Hearing aids are limited to one per ear, as indicated, every three years.

K. **Disposable medical supplies**

Supplies provided which are Medically Necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling an Enrolled Child to effectively carry out a Practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the Enrolled Child's home.

L. **Home and community-based health care services**

(1) Services and supplies required for the administration of Home Infusion Therapy regimen must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Practitioner; (3) as determined by the Utilization Management Program capable of safe administration in the home; (4) provided by a licensed Home Infusion Therapy provider coordinated and pre-certified by the Utilization Management Program; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy.

(2) Benefits for home health nursing services must be approved by the Utilization Management Program in lieu of hospitalization. Benefits for nursing services are limited to $10,000 annually. (Refer to Nursing care services in following section.)

M. **Nursing care services**

(1) Benefits are provided for Covered Expenses when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered. Nurse practitioner services are covered as Medical Services.

(2) Benefits for nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) are covered only when ordered and supervised by a Practitioner and when the services rendered require the technical skills of a RN or LPN.

(3) Benefits for private duty nursing services are provided for an illness or injury that the Utilization Management Program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services.

(4) Benefits are provided for nursing services in the home for illness or injury that the Utilization Management Program determines to require the skills of a RN or LPN. Benefits for nursing services provided in an Enrolled Child's home must be approved by the Utilization Management Program in lieu of hospitalization.

(5) Benefits for nursing services are limited to $10,000 annually. This limit does not apply to nurse practitioner services.

(6) No nursing benefits are provided for the following:
   (a) Services of a nurse who ordinarily lives in the Enrolled Child's home or is a member of the Enrolled Child's family;
   (b) Services of an aide, orderly or sitter; or
   (c) Nursing services provided in a Personal Care Facility.

(7) Benefits are provided for confinement in a skilled nursing facility for up to 60 days per benefit period, subject to utilization management requirements.

N. Abortion

Elective abortions are covered only when documented to be medically necessary in order to preserve the life or physical health of the mother.

O. Dental Services

(1) Benefits are provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). The following Covered Dental Services are limited to $1500 each calendar year:
   (a) Bitewing X-Rays-as needed, but no more frequently than once every six months;
   (b) Complete Mouth X-Ray and Panoramic X-Ray- as needed, but no more frequently than once every twenty (24) months;
   (c) Prophylaxis- one every six (6) months; must be separated by six full months;
   (d) Fluoride Treatment – limited to one each six (6) month period;
   (e) Space maintainers – limited to permanent teeth through age 15;
   (f) Sealants – covered up to age 14, every 36 months.

(2) Benefits are provided for restorative, endodontic, periodontic and surgical dental services as indicated below and are limited to $1500 each calendar year:
   (a) Amalgam, Silicate, Sedative, and Composite Resin Fillings including the replacement of an existing restoration;
   (b) Stainless steel crowns to posterior and anterior teeth;
   (c) Porcelain crowns to anterior teeth only;
   (d) Simple extraction;
   (e) Extraction of an impacted tooth;
   (f) Pulpotomy, pulpectomy and root canal;
   (g) Gingivectomy, gingivoplasty and gingival curettage.

Other Dental Services (The Calendar Year Maximum does not apply to these services.)

(1) Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Enrolled Child is covered under the Plan. Injury to teeth as a result of chewing or biting is not considered an accidental injury.

(2) Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Enrolled Child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office.

(3) No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions.

(4) Benefits are provided for diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a Practitioner or dentist, subject to a lifetime maximum benefit of $5,000 per member. This lifetime maximum will apply regardless of whether the temporomandibular/craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

P. **Substance abuse treatment services**

1. Inpatient substance abuse treatment services and residential substance abuse treatment services:
   (a) Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol

abuse, drug abuse, or a combination of alcohol and drug abuse.

(b) Benefits for covered medical expenses are provided for Medically Necessary inpatient stabilization and residential substance abuse treatment.

(c) Certification of Medical Necessity by the Health Plan's Utilization Management Program is required for admissions to a hospital or residential treatment center.

(d) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

2. Outpatient substance abuse treatment services:

(a) Benefits are provided for covered medical expenses for Medically Necessary Intensified Outpatient Programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility.

(b) Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient.

(c) Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

Q. **Case management services**

Medical Case Management may be performed by the Utilization Management Program of the Health Plan for those Enrolled Children who have a catastrophic or chronic condition. Through medical case management, the Utilization Management Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and Supplies which are not otherwise covered. The decision to provide extended or alternative benefits is made on a case-by-case basis to Enrolled Children who meet the Utilization Management Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits is made by the Utilization Management Program.

R. **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders**

(1) Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the Enrolled Child's Practitioner and provided by a licensed physical therapist.

(2) Benefits are provided for Medically Necessary occupational therapy services prescribed by the Enrolled Child's Practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist.

(3) Benefits are provided for Medically Necessary speech therapy services prescribed by the Enrolled Child's Practitioner and specified in a treatment plan. Speech therapy is not covered for maintenance speech, delayed language development, or articulation disorders.

(4) Benefits are provided for an annual hearing examination, if indicated by the results of a hearing screening.

S. **Hospice care**

Benefits are provided for inpatient and home hospice services, subject to utilization management requirements. Benefits for hospice services are limited to an overall lifetime maximum of $15,000.

T. **Anesthesia**

Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered.

U. **Transplants**

(1) Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies:

(a) the Enrolled Child obtains prior authorization from the Utilization Management Program; and

(b) the condition is life-threatening; and

(c) such transplant for that condition is the subject of an ongoing phase III clinical trial; and

(d) such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and

(e) the Enrolled Child is a suitable candidate for the transplant under the medical protocols used by the Utilization Management Program.

(2) In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure.

(3) Benefits are provided for transportation costs of recipient and one other individual to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of one individual at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two (2) other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses

incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to $10,000.

(4) If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient, the following applies:

(a) The following expenses are covered:

- A search for matching tissue, bone marrow or organ;
- Donor's transportation;
- Charges for removal, withdrawal and preservation;
- Donor's hospitalization.

(b) When only the recipient is an Enrolled Child, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the Enrolled Child's contract.

(c) When both the recipient and the donor are Enrolled Children, the donor is entitled to benefits under the donor's contract.

(d) When only the donor is an Enrolled Child, the donor is not entitled to donor coverage benefits.

(e) If any organ or tissue is sold rather than donated to the Enrolled Child, no benefits are payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered under the Enrolled Child's contract.

V. Manipulative therapy

Manipulative therapy is a covered medical expense, but benefits are limited to $2,000 per benefit period.

W. Optometric services

Benefits are provided for Medically Necessary services and Supplies required for the treatment of injury or disease of the eye which fall within the legal scope of practice of a licensed optometrist. Benefits are provided for an annual routine eye examination, if indicated by the results of a vision screening, and the fitting of eyeglasses.

X. **Medical transportation**

Professional ambulance services to the nearest hospital which is equipped to handle the Enrolled Child's condition in connection with covered hospital inpatient care, or when related to and within 72 hours after accidental bodily injury or medical emergency whether or not inpatient care is required, are covered expenses.

Y. **Surgery for mastectomy and reconstruction of the breast**

When the Health Plan determines the Medically Necessity of medical and surgical benefits with respect to a Member's mastectomy, Benefits will be provided for breast reconstruction when such Covered Services is elected by the Member. In accordance with the terms and provisions of this Benefit Plan, the following benefits will be provided.

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications in connection with all stages of mastectomy, including lymphedemas.

3.4 Covered Providers

A. Benefits shall be allowed for Covered Health Services provided by Network Providers.

B. No Provider paid under the Program may charge an Enrolled Child or the family of an Enrolled Child any amount in excess of the amount paid by the Health Plan for Covered Health Care Services.

ARTICLE 4
LIMITATIONS AND EXCLUSIONS

Notwithstanding any other provisions of these rules and regulations, benefits will be limited, excluded, and conditioned as follows:

4.1 No benefits shall be provided for services or Supplies which are provided for the following:

A. Convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Practitioner for an Enrolled Child who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the Enrolled Child was admitted to a hospital for his or her own convenience or the convenience of his or her Practitioner, or that the care or treatment provided did not relate to the condition for which the Enrolled Child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the Enrolled Child was hospitalized and then only during such time as such services are medically necessary.

B. Cosmetic purposes, except for correction of defects incurred by the Enrolled Child while covered under the Program through traumatic injuries or disease requiring surgery.

C. Sex therapy or marriage or family counseling.

D. Custodial care, including sitters and companions.

E. Elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother.

F. Equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, and so forth).

G. Procedures which are Experimental/Investigative in nature.

H. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

I. Services and Supplies related to infertility, artificial insemination, intrauterine insemination and in vitro fertilization regardless of any claim to be Medically Necessary.

J. Services which the Health Plan determines are not medically necessary for treatment of injury or illness.

K. Services provided under any federal, state, or governmental plan or law including but not limited to Medicare except when so required by federal law.

L. Nursing or personal care facility services, e.g. extended care facility, nursing home, or personal care home, except as specifically provided otherwise.

M. Treatment or care for obesity or weight control including all diet treatments, gastric or intestinal bypass or stapling, or related procedures regardless of degree of obesity or any claim to be medically necessary.

N. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

O. Inpatient rehabilitative services consisting of the combined use of medical, social, educational or vocational services, or any such services designed to enable Enrolled Children disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by the Utilization Management Program.

P. Outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable Enrolled Children disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the Enrolled Child's Practitioner and provided by a licensed therapist.

Q. Care rendered by a Provider, who is related to the Enrolled Child by blood or marriage or who regularly resides in the Enrolled Child's household.

R. Services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.

S. Treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease.

T. Reversal of sterilization regardless of claim of medical necessity.

U. Charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain medical records or information required to adjudicate a claim.

V. Travel, whether or not recommended by a Practitioner, except as provided for under Transplant Benefits.

W. Services related to diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.

X. Treatment of any injury arising out of or in the course of employment or any sickness entitling the Enrolled Child to benefits under any Workers' Compensation or Employer Liability Law.

Y. Any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the Enrolled Child is unable to recover from the responsible party, benefits of the Program shall be provided.

ARTICLE 5
APPEALS AND GRIEVANCES

5.1 Health Plan shall provide a 3 (three) level review process for appeals. This process is as follows:

A. First Level Review

1. The Member, his or her representative or a Provider may initiate the appeal process by filing a verbal or written appeal within forty-five calendar days of the incident, or at which time the Member has knowledge of the circumstances which would give rise to the appeal, whichever comes first.

2. Health Plan's Appeals Coordinator will investigate the appeal Using applicable statutory, regulatory and contractural provisions, as well as the Health Plan's written policies.

3. Within fifteen (15) calendar days after receipt of the appeal, the Appeals Coordinator or Medical Director when necessary, will prepare and send a notice, outlining the Health Plan's determination, to the Member and/or Provider.

4. The notice, which will be sent first class mail, will contain the following information:

   a. The title(s) and qualifying credentials(s) of the person(s) participating in the appeal review process:

   b. A statement of the reviewer's understanding of the appeal;

   c. The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail; and

   d. A reference to the evidence or documentation used as the basis for the decision.

   e. If the decision is a denial, a clear description of the individual's right to and the process required for further review.

5. Upon Members request, and for both a legitimate reason and a reasonable period, the fifteen (15) calendar day time frame referenced in this section for step one may be extended. The Member must be informed that an extension of the time frame for this step could also extend the total grievance appeal process time frame to more than 90 days.

B. Second Level Review

1. If the Member, his or her representative or the Provider is dissatisfied with Health Plan's decision on an appeal, the Member, his or her representative or the Provider may send to the Health Plan a written statement containing an explanation of the appeal and reason(s) for dissatisfaction with Health Plan's decision. This written request must be received by Health Plan within fifteen (15) calendar days of the member's and/or Provider's receipt of Health Plan's decision. This written request must be received by Health Plan's decision.

2. Health Plan will investigate each appeal using applicable statutory, regulatory, and contractual provisions, as well as the Health Plan's written policies. As part of the investigation, Health Plan:

   a. May contact the Member and/or the appropriate provider by phone or in person:

   b. Will consult with its management, and /or Medical Director, as necessary, and, if the appeal involves an adverse medical determination, Health Plan's Consulting providers who have appropriate expertise in the area which is the subject of the appeal;

   c. Health Plan will render a decision on the appeal within fifteen (15) calendar days of the receipt of the appeal. Health Plan will send a written decision to the Member and Provider within the fifteen (15) calendar days of the receipt of the appeal;

   d. The written decision shall be in the form of a Notice. The Notice, which will be sent first class mail, shall contain the following information:

      i. The names(s), title(s) and qualifying credentials(s) of the person(s) participating in the appeal review process;

      ii. A statement of the reviewer's understanding of the appeal;

      iii. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

      iv. A reference to the evidence or documentation used as the basis for the decision; and

      v. If the decision is a denial, a clear description of the individual's right to and the process required for further review.

e. If the Member is dissatisfied with the result of the Health Plan's appeal decision, he or she may continue the appeal process by filing a written request along with additional information that may be available for reconsideration of the appeal with Health Plan, within fifteen (15) calendar days of receipt of Health Plan's notice regarding the appeal.

C. Third Level of Review

1. If the Member, his or her representatives or the Provider remains dissatisfied with the Health Plan's decision on the appeal, he or she must send to the Health Plan a written statement restating the appeal and the reason(s) for the dissatisfaction within Health Plan's decision, along with any additional information pertinent to the appeal. Health Plan must receive the written statement within 15 days of the Member's and/or Provider's receipt of Health Plan's decision on the appeal.

2. The Health Plan will review the request for reconsideration and any new information that may have become available since the time the appeal was first considered.

3. The individuals reviewing the reconsideration shall not be the same individuals that Health Plan utilized in the initial determination when the appeal was denied. In the event the third level appeal review involves a final adverse determination being made by Health Plan about the denial, reduction, suspension or termination of health care services or treatment, other than for timeliness, the Appeals Coordinator, within ten (10) calendar days of the Health Plan's receipt of the individuals third request, will refer all pertinent documentation relating to the request to the Health Plan's legal department for final determination. The Health Plan will refer the medical determinations to an external independent review organization for a final determination of the appeal. Such documentation shall include:

   a. All files associated with the step one, step two and step three appeals by Health Plan's staff, including all documentation assembled during the reviews;

   b. The Member's pertinent medical records;

   c. The attending physician's recommendations;

   d. Consulting reports from appropriate health care professions;

   e. Other documents submitted by the Member, his/her representative, or a provider;

f. Any applicable generally accepted practice guidelines, including those developed by the federal government, national or professional medical societies, boards or associations; and

g. Any applicable clinical review criteria developed and/or used by the Health Plan.

The independent external review organization must thoroughly review all documentation provided by the Health Plan and make a final determination regarding the Appeal. Such review and written notice to the Health Plan shall be completed within fifteen (15) calendar days of receipt. The notice to the Health Plan shall identify the qualifying credentials of the person(s) participating in the review and thoroughly explain the basis for the final determination.

4. Once the third level appeal review is complete. Health Plan shall send a notice, by first class mail outlining the determination, to the Member and Provider. The notice shall contain:

   a. The title(s) and qualifying credential(s) of the person(s) participating in the reconsideration process, if applicable;

   b. A statement of the reviewer's understanding of the appeal.

   c. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

   d. A reference to the evidence or documentation used as the basis for the decision.

   e. If the decision is a denial, a clear description of the individual's right to the process required for further review.

2. Expedited Appeal Procedures

   A. The Health Plan shall provide an expedient review of an appeal involving an urgent or emergency medical situation. This process is as follows:

      1. This process shall include all requests by Members concerning admissions, availability of care, continued stay or health care services being received by a Member in an emergency situation where he or she has not been discharged from a facility (hospital). The request for an expedited review may be submitted by the Member, his or her representative or a Provider verbally to a designated representative of the Health Plan.

2. In the expedited review process, all necessary information, including Health Plan's decision, shall be transmitted between Health Plan, the independent review organization (where applicable), the Member, his or her representative or the Provider by telephone, facsimile or the most expeditious method.

3. The Health Plan shall make a decision and notify the Member and his or her representative as expeditiously as the member's medical condition requires, but in no event more than seventy-two (72) hours after the review is requested. Health Plan shall provide written confirmation of its decision concerning an expedite review within two (2) working days of providing notification of that decision if the initial notification was not in writing.

B. The written decision shall be in the form of a Notice. The Notice, which will be sent first class mail, shall contain the following information:

1. The title(s) and qualifying credential(s) of the person(s) participating in the appeal review process;

2. The qualifying credentials of any independent external review organization staff participating in the review;

3. A statement of the reviewer's understanding of the appeal;

3. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

4. A reference to the evidence or documentation used as the basis for the decision; and

5. An explanation of how to request a reconsideration of an appeal decision.

6. If the decision is a denial, a clear description of the individuals right to pursue the matter in a court of appropriate jurisdiction.

Exception: Upon member request, and for both a legitimate reason and a reasonable period, the seventy-two hour (72) hour timeframe referenced in this section may be extended by up to fourteen (14) calendar days.

3. Grievance Process

a. The Member, his or her representative or a Provider may initiate a grievance either verbally or in writing. By initiating a grievance, one is expressing dissatisfaction with the benefit plan, services rendered, benefit plan policies and/or claims processing timeliness.

b. The Health Plan's Appeals Coordinator will investigate the grievance using applicable statutory, regulatory and contractual provisions, as well as Health Plan's written policies. As necessary, the Appeals Coordinator will confer with individuals responsible for operational activities directly related to the grievance.

c. Within thirty (30) calendar days after receipt of the grievance, the Appeals Coordinator will prepare and send a notice, outlining Health Plan's responses to the Member and/or Provider.

ARTICLE 6
UTILIZATION MANAGEMENT

6.1 The Health Plan may conduct such utilization management activities as are necessary to ensure that Covered Health Care Services provided Enrolled Children are Medically Necessary.

6.2 Utilization management activities conducted by the Health Plan may cause undue hardship on Enrolled Children or their families in accessing Covered Health Care Services.

6.3 The Health Plan must allow for retrospective review for Medical Necessity after medical services have been provided in the event of failure to pre-certify or notify the Utilization Management Program.

6.4 Medical Case Management may be performed by the Utilization Management Program for those Enrolled Children who have a catastrophic or chronic condition. Through medical case management, the Utilization Management Program may elect to (but is not required to) extend covered benefits beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and Supplies which are not otherwise covered under the Program. The decision to provide extended or alternative benefits shall be made on a case-by-case basis to Enrolled Children who meet the Utilization Management Program's criteria then in effect. Any decision regarding the provision of extended or alternative benefits shall be made by the Health Plan.

6.5 As set forth in Article 3, certain services may be subject to review of Medical Necessity and require pre-approval.

6.6 The Health Plan shall provide a means by which the parent/guardian of the Enrolled Child may receive approval to access out of network services if the needed medical service is not available in the Health Plan's network.

ARTICLE 7
GENERAL CONDITIONS

7.1 Neither the Board nor Department of Finance and Administration shall be liable for or on account of any fault, act, omission, negligence, misfeasance, malfeasance, or malpractice on the part of any Hospital or other institution, or any agent or employee thereof, or on the part of any Health Care Professional or other person participating in or having to do with the care or treatment of the Enrolled Child.

7.2 The benefits for Covered Health Care Services shall be provided only to the extent that the Provider can provide such service, and payment therefore to the Provider by the Health Plan as herein provided shall constitute a complete discharge of the obligation of the Program hereunder with respect thereto.

7.3 Any notice required to be given by Health Plan to Enrolled Child hereunder shall be deemed to be given and delivered when deposited in the United States mail, postage prepaid, addressed to the Enrolled Child or parent/guardian at the address that appears in the records of the Health Plan.

7.4 Persons claiming benefits under the Program must furnish the State or the Health Plan such information as may be necessary to administer benefits under the program.

7.5 Each Enrolled Child receiving care under the Program authorizes and directs any Provider to furnish to the Health Plan at any time upon request all information, records, copies of records, or testimony relating to attendance, diagnosis, examination, or treatment, and by such authorization, expressly waives any and all laws providing for privileged communications between Health Care Professional and patient. Such authorization and waiver, and compliance therewith by each Provider affected, shall be a condition precedent to rights to benefits to each Enrolled Child covered under the Program, and no benefits shall be provided in any case where such authorization and waiver is not given full effect.

7.6 The Health Plan will hold information, records, or copies of records concerning Enrolled Children as confidential. The Health Plan will restrict the use or disclosure of information concerning Enrolled Children to purposes directly connected with the administration of the Program. Information considered confidential is to include, but not be limited to, the following:

A. Names and addresses;
B. Medical services provided;
C. Social and economic conditions or circumstances;
D. Medical history, including diagnoses and treatments; and
E. Information related to the liability of third parties.

7.7 Any materials distributed to Enrolled Children or their families must directly relate to the administration of the Program.

7.8 Proof of Loss

A. Written proof of loss for which claim is made should be furnished to Health Plan as soon as possible after the covered service is rendered. The deadline for filing claims for covered services rendered by network providers is subject to the provisions set forth in the Health Plan's network provider contracts. Claims for covered services rendered by non-network providers, and approved by the Health Plan, must be filed within the timeframe agreed to by the Health Plan, but in no case later than the end of the calendar year following the year in which the services were provided.

B. Upon failure of an Enrolled Child or Provider to so notify the Health Plan or furnish proof of loss, payment may be refused or a percentage of the regular payment provided may be paid at the option of the Health Plan; provided, however, failure to give notice of proof of loss within the time provided shall not invalidate a claim if it can be shown that compliance with this provision was not reasonably possible and that notice of claim was given as soon as reasonably possible.

7.9 The Health Plan may enforce reimbursement or subrogation rights by requiring the Enrolled Child or parent/guardian to assert a claim to any of the foregoing coverages to which he/she may be entitled.

7.10 If the Health Plan is notified that an Enrolled Child may have other creditable health coverage, the Health Plan will notify the Division of Medicaid for further investigation.

7.11 The Health Plan is authorized to make payment directly to Health Care Professionals, Hospitals, or other Covered Providers furnishing services for which benefits are provided under the Program.

7.12 Whenever any condition or requirement of the Program has been breached by an Enrolled child or he/she shall be in default as to any term or condition hereof, failure of the Board, the Department of Finance and Administration or the Health Plan to avail of any right stemming from such breach or default, or indulgences granted, shall not be construed as a

waiver of the right of the Board, Department of Finance and Administration or the Health Plan on account of existing or subsequent such breach or default.

7.13 In the event the Program is terminated, such termination alone shall operate to terminate all rights of the Enrolled Child to benefits under the Program, as of the effective date of termination.

7.14 In the event any Enrolled Child's coverage is terminated under the Program, such termination shall operate to terminate all rights of the Enrolled Child to benefits under the Program, as of the effective date of termination.

ARTICLE 8
CONTINUATION COVERAGE

8.1 There are no continuation of coverage options under the Program for children whose eligibility has terminated.

8.2 The Health Plan will issue a Certificate of Creditable Coverage to children whose coverage has terminated.