

(2) Section 2103 of the Act, which outlines coverage requirements for children's health insurance;

(3) Section 2109 of the Act, which describes the relation of the CHIP program to other laws;

(4) Section 2110(a) of the Act, which describes child health assistance; and

(5) Section 2110(c) of the Act, which contains definitions applicable to this subpart.

(b) *Scope.* This subpart sets forth requirements for health benefits coverage and child health assistance under a separate child health plan.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to a Medicaid expansion program.

**§ 457.402 Definition of child health assistance.**

For the purpose of this subpart, the term "child health assistance" means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

- (a) Inpatient hospital services.
- (b) Outpatient hospital services.
- (c) Physician services.
- (d) Surgical services.
- (e) Clinic services (including health center services) and other ambulatory health care services.
- (f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
- (g) Over-the-counter medications.
- (h) Laboratory and radiological services.
- (i) Prenatal care and pre-pregnancy family planning services and supplies.
- (j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
- (k) Outpatient mental health services, other than services described in paragraph (s) of this section but including services furnished in a State-oper-

ated mental hospital and including community-based services.

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

(m) Disposable medical supplies.

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

**§ 457.410**

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

**§ 457.410 Health benefits coverage options.**

(a) *Types of health benefits coverage.* States may choose to obtain any of the following four types of health benefits coverage:

(1) Benchmark coverage in accordance with § 457.420.

(2) Benchmark-equivalent coverage in accordance with § 457.430.

(3) Existing comprehensive State-based coverage in accordance with § 457.440.

(4) Secretary-approved coverage in accordance with § 457.450.

(b) *Required coverage.* Regardless of the type of health benefits coverage, described at paragraph (a) of this section, that the State chooses to obtain, the State must obtain coverage for—

(1) Well-baby and well-child care services as defined by the State;

(2) Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and

(3) Emergency services as defined in § 457.10.

**§ 457.420 Benchmark health benefits coverage.**

Benchmark coverage is health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit plans:

(a) *Federal Employees Health Benefit Plan (FEHBP).* The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under, 5 U.S.C. 8903(1).

(b) *State employee plan.* A health benefits plan that is offered and generally available to State employees in the State.

**42 CFR Ch. IV (10–1–14 Edition)**

(c) *Health maintenance organization (HMO) plan.* A health insurance coverage plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, non-Medicaid enrollment in the State.

**§ 457.430 Benchmark-equivalent health benefits coverage.**

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value determined in accordance with § 457.431 that is at least actuarially equivalent to the coverage under one of the benchmark packages specified in § 457.420.

(b) *Required coverage.* In addition to the coverage required under § 457.410(b), benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(c) *Additional coverage.* (1) In addition to the categories of services in paragraph (b) of this section, benchmark-equivalent coverage may include coverage for any additional services specified in § 457.402.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.