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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-25-0035

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Children and Adults Health Programs Group

March 24, 2026

Julie Ewing
Medicaid Director
Director, Division of Integrated Healthcare
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Director Ewing:

Your Title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) UT-25-0035, submitted on June 24, 2025, with additional information submitted on March 18, 2025, has been approved. The effective date for this SPA is June 3, 2025.

Through SPA UT-25-0035, Utah removes all monetary annual and lifetime limits from the CHIP state plan in accordance with 42 CFR 457.480(a), as detailed in Attachment A. In addition, the state provides assurance that no annual, lifetime, or other aggregate dollar limitations are imposed on any medical or dental services covered under the CHIP state plan.

Your Project Officer is Kristin Pacek. She is available to answer your questions concerning this amendment and other CHIP-related matters and can be reached at Kristin.Pacek@cms.hhs.gov.

If you have additional questions, please contact Mary Beth Hance, Acting Director, Division of State Coverage Programs, at (410) 786-4299. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Jessica Stephens/

Jessica Stephens
Acting Director

Attachment A – Revisions to Benefit Limitations in UT-25-0035

The following monetary limitations on medical or dental benefits were removed and/or revised:

- $1,000 annual limitation for dental services.
- $35,000 lifetime maximum benefit for bilateral cochlear implants. The state replaces this with a once per lifetime maximum benefit.
- $1,000 lifetime limitation for orthodontia.

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: The State of Utah

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Julie Ewing	Position/Title: Medicaid Director, Director of Integrated Healthcare
Name: Jennifer Meyer-Smart	Position/Title: Acting CHIP Director
Name:	Position/Title:

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan

Effective Date: July 10, 1998

Implementation Date: August 1, 1998

SPA # 10 , Purpose of SPA: Rebenchmark CHIP benefits

Proposed effective date: November 19, 2011

Proposed implementation date: November 19, 2011

SPA # 11 , Purpose of SPA: Express Lane Eligibility and Presumptive Eligibility -pending

Proposed effective date: ELE- September 1, 2011; Presumptive Eligibility- April 1, 2012

Proposed implementation date: ELE- September 1, 2011; PE- April 1, 2012

SPA # 12 , Purpose of SPA: Rebenchmark CHIP benefits

Proposed effective date: July 1, 2012

Proposed implementation date: July 1, 2012
Withdrawn

SPA # 13 , Purpose of SPA: Rebenchmark CHIP benefits

Proposed effective date: July 1, 2012

Proposed implementation date: July 1, 2012

SPA # 14 , Purpose of SPA: Eliminate Presumptive Eligibility for children that meet the requirements of section 1920A of the Act. (Section 2107 (e)(1)(L)); (42 CFR 457.355)
Removing references to Plan A.

Proposed effective date: November 1, 2014

Proposed implementation date: November 1, 2014

SPA# 15, Purpose of SPA: Ex Parte Reviews

Proposed effective date: February 1, 2015

Proposed implementation date: February 1, 2015

SPA# 16, Purpose of SPA: Change Reports

Proposed effective date: November 1, 2015

Proposed implementation date: November 1, 2015

SPA# 17, Purpose of SPA: Rebenchmark CHIP dental benefits

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

Proposed implementation date: July 1, 2016
SPA# 18, Purpose of SPA: FQHC Payment Methodology

Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

SPA #20 Purpose of SPA: CHIP Mental Health Parity and Addiction Equity Act Analysis, Removal of Co-Payment Requirements for Residential Treatment and the Removal of Co-payment Requirements for Mental Health and Substance Use Disorder Services in an Urgent Care Clinic

Proposed effective date: July 1, 2021

Proposed implementation date: July 1, 2021

SPA# 21, Purpose of SPA: Update CHIP benefits

Proposed effective date: July 1, 2019

Proposed implementation date: July 1, 2019

SPA# 22, Purpose of SPA: Add CHIP Disaster Relief COVID-19 Plan.
The Secretary of the Department of Health and Human Services declared a public health emergency (PHE) on January 31, 2020, under section 319 of the

Public Health Service Act (42 U.S.C. 247d), in response to COVID-19, followed by a National Emergency declaration signed by the President on March 13, 2020. In response to this declaration, the State will implement changes related to tribal consultation, eligibility and redeterminations, premiums and cost sharing processes. The duration of the policy will be determined by the end of the federally declared PHE.

Proposed effective date: March 1, 2020

Proposed implementation date: March 1, 2020

SPA # 23, Purpose of SPA: Implement the requirements of section 5022 of the SUPPORT Act

Proposed effective date: July 1, 2020

Proposed implementation date: July 1, 2020

SPA# 24, Delay timeliness requirements on ex parte renewals.

Proposed effective date: February 1, 2021

Proposed implementation date: February 1, 2021

SPA# 25, Purpose of SPA: Update CHIP Benefits

Proposed effective date: July 1, 2021

Proposed Implementation date: July 1, 2021

SPA# 26, Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the
American Rescue Plan Act provisions that require states to cover treatment (including treatment
of a condition that may seriously complicate COVID-19 treatment), testing and vaccinations for
COVID-19 without cost sharing in CHIP

Proposed effective date: March 11, 2021

Proposed implementation date: March 11, 2021

SPA# UT-22-0027, Purpose of SPA: To include provisions of reimbursement for single-day patient encounters in an FQHC and RHC and to update and clarify the prospective payment and alternative payment methodologies for ran FQHC and RHC

Proposed effective date: May 1, 2022

Proposed implementation date: May 1, 2022

SPA# UT-23-0028, Purpose of SPA: The purpose of this SPA is to update the CHIP out of pocket maximum member notification process.

Proposed effective date: April 1, 2023

Proposed implementation date: April 1, 2023

SPA# UT-23-0029, Purpose of SPA: To update the CHIP dental benchmark plan and benefits.

Proposed effective date: July 1, 2023

Proposed implementation date: July 1, 2023

SPA# UT-24-0031, Purpose of SPA: The State is assuring that it covers age-appropriate vaccines and their administration, without cost sharing.

Proposed effective date: July 1, 2024

Proposed implementation date: July 1, 2024

SPA# UT-25-0035, Purpose of SPA: To eliminate annual and lifetime dollar limits for CHIP benefits.

Proposed effective date: June 3, 2025

Proposed implementation date: June 3, 2025

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

State Plan Amendments 10 & 11 was presented at the Indian Health Advisory Board meeting on October 7, 2011. There was no request for consultation.

State Plan Amendment 13 was presented at the Utah Indian Health Advisory Board meeting on August 3, 2012. Consultation was not requested.

State Plan Amendment 14 was presented at the Utah Indian Health Advisory Board meeting on 08/08/2014. Consultation was not requested.

State Plan Amendment 15 was presented at the Utah Indian Health Advisory Board meeting on 12/12/2014. Consultation was not requested.

State Plan Amendment 16 was presented at the Utah Indian Health Advisory Board meeting on 10/9/2015. Consultation was not requested.

State Plan Amendment 17 was presented at the Utah Indian Health Advisory Board meeting on 7/8/2016. Consultation was not requested.

State Plan Amendment 18 was presented at the Utah Indian Health Advisory Board meeting on 3/10/2017. Consultation was not requested.

State Plan Amendment 20 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2018. Consultation was not requested.

State Plan Amendment 21 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2019. Consultation was not requested.

State Plan Amendment 22 in concept was presented at the Utah Indian Health Advisory Board meeting on April 10. The final SPA was presented to the board on May 8, 2020, after the SPA was submitted to CMS. To address the Federal COVID-19 public health emergency, the State received waiver approval under section 1135(b)(5) of the Act, for flexibility to modify the timeframes associated with tribal consultation, including conducting consultation after submission of the SPA.

Consultation was not requested.

State Plan Amendment 23 was presented at the Indian Health Advisory Board meeting on August 14, 2020. There was no request for consultation.

State Plan Amendment 24 was presented to the Utah Indian Health Advisory Board meeting on February 12, 2021, again after CMS guidance on March 12, 2021, and finally a status update on April 9, 2021. Consultation was not requested.

State Plan Amendment 25 was presented to the Utah Indian Health Advisory Board meeting on August 13, 2021. Consultation was not requested.

State Plan Amendment 26 was presented to the Utah Indian Health Advisory Board meeting on March 11, 2022. Consultation was not requested.

State Plan Amendment UT-22-0027 was presented to the Utah Indian Health Advisory Board meeting on April 8, 2022. Consultation was not requested.

State Plan Amendment UT-23-0028 was presented to the Utah Indian Health Advisory Board meeting on January 13, 2023. Consultation was not requested.

State Plan Amendment UT-23-0029 was presented to the Utah Indian Health Advisory Board meeting on June 9, 2023. Consultation was not requested.

State Plan Amendment UT-24-0031 was presented to the Utah Indian Health Advisory Board meeting on June 21, 2024. Consultation was not requested.

State Plan Amendment UT-24-0014 was presented to the Utah Indian Health Advisory Board meeting on June 21, 2024. Consultation was not requested.

State Plan Amendment UT-25-0035 was presented to the Utah Indian Health Advisory Board meeting on June 13,2025. Consultation was not requested.

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

The state assures that no annual, lifetime or other aggregate dollar limitations are imposed on any medical or dental services covered under the CHIP State plan consistent with 42 CFR 457.480(a).

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Vision Care:

Scope of Coverage

Services provided by licensed ophthalmologists or licensed optometrists, within their scope of practice.
Services include:
A. Routine vision examinations.
B. One exam every 12 months.

Hearing Services

Scope of Coverage

Screening services provided by a licensed medical professional/audiologist to test for any hearing loss.

One exam every 12 months.

Bilateral cochlear implants are covered ~~up to a lifetime maximum of $35,000~~once per lifetime. ~~–~~The surgery itself (facility, anesthesia, physician's fees, etc.) and the implant device apply to this limit. Aural rehabilitation related to an approved cochlear implantation is subject to speech therapy benefit limitations but does not apply to the maximum plan ~~payment~~benefit. Maintenance on the device, such as replacement batteries, is a covered service~~ and does not apply to the maximum plan paymentbenefit~~, whether or not the implant was performed while covered by CHIP. If external components of the device are covered by a warranty, the State, through its contracted Managed Care Organizations, will manage the replacement of those components during the warranty period.

Except for cochlear implants, the purchase, fitting, or ongoing evaluation of

hearing aids, appliances, auditory brain implants, bone anchored hearing aids, or any other procedure or device intended to establish or improve hearing or sounds recognition is not covered.

8.2.3. Coinsurance or copayments:

The following are the co-payment and co-insurance requirements for participation in CHIP. Levels of co-payments will be limited to the income groups identified in the federal enabling legislation 2103(e)(3)(A) & (B).

Plan B Co-Payment requirements:

Hospital Services:

$150 co-payment after deductible for inpatient services.

Co-insurance, 5% for surgeon and anesthesiologist services.

$5 co-payment for urgent care center services and emergency use of the emergency room.

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

Co-insurance, 5% after deductible for outpatient hospital services.

Ambulance (air and ground) for medical emergencies:

Co-insurance, 5% after deductible

Physician Office Visits (includes visits to a Specialist):

$5 co-payment per visit.

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

Prescription Drugs:

$5 co-payment per prescription for generics

Co-insurance, 5% per prescription for brand name drugs.

Laboratory and X-ray Services:

$0 co-payment for laboratory and x-ray services for minor diagnostic tests and x-rays

Co-insurance, 5% after deductible for major diagnostic tests and x-rays

Vision Screening Services:

$5 co-payment (limit of one exam per plan year).

Hearing Screening Services:

$5 co-payment (limit of one exam per plan year).

Dental Services :

~~Maximum benefit of $1,000 per person, per year~~

$0 co-payment for cleanings, exams, x-rays, fluoride, and sealants.

5% co-insurance for all other covered services.

Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index

Mental Health Services, Inpatient Facility:

$150 co-payment after deductible for each visit

Mental Health Services, Outpatient Office Visit and Urgent Care:

$0 co-payment for each visit

Residential Treatment:

$0 co-payment

Home Health and Hospice Care:

Co-insurance of 5% after deductible per visit.

Medical Equipment and Supplies:

Co-insurance of 5% after deductible

Physical, Occupational and Speech Therapy:

$5 co-payment, 20 visits combined limit per child, per plan year.

Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder:

-$0 co-payment

Out- of-Pocket Maximum:

5% of a family's annual gross countable income. Only out of pocket costs for covered services, deductibles, co-pays, and premiums will be used to calculate the maximum out of pocket limit.

Plan C Co-Insurance and Co-Payment requirements:

Hospital Services:

Co-insurance, 20% after deductible for inpatient services

$300 co-payment for emergency or non-emergency use of the emergency room, after deductible ; $300 per visit for non participating hospitals, after deductible

$40 co-payment each urgent care center visit

Co-insurance of 20% of total charges for surgeon and anesthesiologist services, after deductible.

Co-insurance, 20% after deductible for outpatient services.

Ambulance (air and ground) for medical emergencies:

Co-insurance, 20% after deductible

Physician office visits:

$25 co-payment per visit (excluding visits to a Specialist)

$40 co-payment per visit to a Specialist.

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

Prescription Drugs:

$15 co-payment per prescription for generic drugs; Co-insurance 25% of total or brand name drugs on the approved list. Co-insurance 50% of total per prescription for brand name drugs not on the approved list.

Laboratory and X-Ray Services:

$0 co-payment for minor diagnostic tests and x-rays.

Co-insurance, 20% after deductible for major diagnostic tests and x-rays.

Vision Screening Services:

$25 co-payment, limit of one exam per plan year.

Hearing Screening Services:

$25 co-payment, limit of one exam per plan year.

Dental Services:

~~Maximum benefit of $1,000 per person, per year.~~

Plan pays 100% for cleanings, exams, x-rays, fluoride, and sealants.

Co-insurance, 20% after deductible for all other covered services.

Co-insurance, 50% after deductible for porcelain-fused crowns (not Covered for non-adult and back teeth).

Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index.

Mental Health Services In-Patient Facility

Co-insurance, 20% after deductible.

Mental Health Services Outpatient Office Visit and, Urgent Care:

$40 co-payment for each visit

Residential Treatment:

$0 co-payment

Home Health and Hospice Care:

Co-insurance, 20% after deductible

Medical Equipment and Supplies:

Co-insurance, 20% after deductible

Physical, Occupational and Speech Therapy:

$40 co-payment after deductible, 20 visits combined limit, per child, per plan year.

Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder:

-$0 co-payment

Out-of-Pocket Maximum

The maximum out of pocket expense is 5% of a family's annual gross income. Only out of pocket costs for covered services, deductibles, co-pays, and premiums will be used to calculate the maximum out of pocket limit.

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.

- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
    - Total 1-year cost of adding prenatal coverage
    - Estimate of unborn children covered in year 1

CHIP Budget

STATE:	**FFY Budget**
Federal Fiscal Year	~~**2023**~~ **2026**
State's enhanced FMAP rate	~~**23.87%**~~**73.72%**
Benefit Costs	
Insurance payments	$~~0~~237,000
Managed care	$34,184,400 ~~$21,939,400~~
Managed Care Payments (MCHIP)	$143,429,500~~$108,845,600~~
per member/per month rate	$234.23 ~~$197.27~~
Fee for Service	$193,300~~$0~~

STATE:	FFY Budget
Total Benefit Costs~~Health Service Initiatives~~	**$178,044,200**~~$2,043,100~~
(Offsetting beneficiary cost sharing payments)~~**Total Benefit Costs**~~	-$8,217,600~~**$130,859,500**~~**180,087,300**
Net Benefit Costs~~(Offsetting beneficiary cost sharing payments)~~	**$169,826,600**~~-$8,217,600~~
Cost of Proposed SPA Changes – Benefit~~**Net Benefit Costs**~~	**$552,700**~~**$171,869,700**~~ ~~**$122,282,900**~~
Administration Costs~~**Cost of Proposed SPA Changes – Benefit**~~	~~**$552,700**~~ ~~**$74,500**~~
Personnel~~**Administration Costs**~~	$481,500
General administration~~Personnel~~	$1,275,800~~$481,500~~ ~~$566,300~~
~~General administration~~	~~$1,275,800~~ ~~$1,143,600~~
Contractors/Brokers	$2,028,700
Claims Processing~~Contractors/Brokers~~	$0~~$2,028,700~~~~$2,800,000~~ ~~$0~~
Outreach/marketing costs~~Claims Processing~~	$650,000~~$0~~

STATE:	FFY Budget
Health Services InitiativesOutreach/marketing costs	$2,043,100$650,000
OtherHealth Services Initiatives	$2,225,400
Total Administration Costs Other	**$8,704,500**$2,225,400$1,994,200
10% Administrative Cap**Total Administration Costs**	$18,869,600**$6,661,400** **$6,504,100**
Cost of Proposed SPA Changes10% Administrative Cap	$19,096,600 $13,587,000
Federal Share**Cost of Proposed SPA Changes**	$132,020,577131,616,700
State ShareFederal Share	$47,063,22346,914,400$131,616,700 $98,045,500
Total Costs of Approved CHIP Plan State Share	**$178,531,100179,083,800**$46,914,400 $30,741,500
	$178,531,100 **$128,787,000**

NOTE: Include the costs associated with the current SPA.

STATE:	FFY Budget
The Source of State Share Funds: State General Funds/Tobacco Settlement Funds~~Total Costs of Approved CHIP Plan~~ ~~NOTE: Include the costs associated with the current SPA.~~ ~~The Source of State Share Funds: State General Funds/Tobacco Settlement Funds~~	