CHIP and CHIP Perinatal Covered Services

Covered CHIP services must meet the CHIP definition of Medically Necessary Covered Services. The services supporting Members with ongoing or chronic conditions must be authorized in a manner that reflects the Member's ongoing need for such services and supports. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Covered CHIP Perinatal services must meet the definition of Medically Necessary Covered Services. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Members. CHIP Perinate Newborns are eligible for 12-months continuous coverage, beginning with the month of enrollment as a CHIP Perinate.

Covered	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: ▪ Hospital-provided Physician or Provider services ▪ Semi-private room and board (or private if medically necessary as certified by attending) ▪ General nursing care ▪ Special duty nursing when medically necessary ▪ ICU and services ▪ Member meals and special diets ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component) ▪ Surgical dressings, trays, casts, splints ▪ Drugs, medications and biologicals ▪ Blood or blood products that are not provided free-of-charge to the Member and their administration ▪ X-rays, imaging and other radiological tests (facility technical component) ▪ Laboratory and pathology services (facility technical component) ▪ Machine diagnostic tests (EEGs, EKGs, etc.) ▪ Oxygen services and inhalation therapy ▪ Radiation and chemotherapy ▪ Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care ▪ In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. ▪ Hospital, physician and related medical services, such as anesthesia, associated with dental care ▪ Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: ▪ Operating, recovery and other treatment rooms ▪ Anesthesia and administration (facility technical component Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: ▪ all stages of reconstruction on the affected breast; ▪ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ▪ cleft lip and/or palate; or ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Drugs, medications and biologicals that are medically necessary prescription and injection drugs. ▪ Outpatient services associated with (a) miscarriage or (b) a non-

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ Respiratory services - Radiation and chemotherapy ▪ Blood or blood products that are not provided free-of-charge to the Member and the administration of these products ▪ Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples. ▪ Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. ▪ Surgical implants ▪ Other artificial aids including surgical implants ▪ Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: ▪ all stages of reconstruction on the affected breast; ▪ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ▪ cleft lip and/or palate; or ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples. (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or nonviable pregnancy. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. (5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.
Physician/ Physician Extender Professional Services	Services include, but are not limited to, the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) ▪ Physician office visits, inpatient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation ▪ Medications, biologicals and materials administered in Physician's office ▪ Allergy testing, serum and injections ▪ Professional component (in/outpatient) of surgical services, including: ▪ Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care ▪ Administration of anesthesia by Physician (other than surgeon) or CRNA ▪ Second surgical opinions ▪ Same-day surgery performed in a Hospital without an over-night stay ▪ Invasive diagnostic procedures such as endoscopic examinations ▪ Hospital-based Physician services (including Physician-performed technical and interpretive components) ▪ Physician and professional services for a mastectomy and breast reconstruction include: ▪ all stages of reconstruction on the affected breast; ▪ external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed ▪ surgery and reconstruction on the other breast to produce symmetrical appearance; and ▪ treatment of physical complications from the mastectomy and treatment of lymphedemas. ▪ In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96	Services include, but are not limited to the following: ▪ Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth ▪ Physician office visits, inpatient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation ▪ Medically necessary medications, biologicals and materials administered in Physician's office ▪ Professional component (in/outpatient) of surgical services, including: ▪ Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. ▪ Administration of anesthesia by Physician (other than surgeon) or CRNA ▪ Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. ▪ Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) ▪ Hospital-based Physician services (including Physician performed

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	hours following an uncomplicated delivery by caesarian section. ▪ Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: ▪ dilation and curettage (D&C) procedures; ▪ appropriate provider-administered medications; ▪ ultrasounds, and ▪ histological examination of tissue samples. ▪ Physician services medically necessary to support a dentist providing dental services to a CHIP Member such as general anesthesia or intravenous (IV) sedation. ▪ Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: ▪ cleft lip and/or palate; or ▪ severe traumatic skeletal and/or congenital craniofacial deviations; or ▪ severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	technical and interpretive components) ▪ Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. ▪ Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. ▪ Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C) procedures; • appropriate provider-administered medications; • ultrasounds, and • histological examination of tissue samples.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Covered, unlimited prenatal care and medically necessary care related to diseases, illness, or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services. Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 Days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery) Limitation: Applies only to CHIP Members.	Covers birthing services provided by a licensed birthing center. Limited to facility services related to labor with delivery. Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born).
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	CHIP Members: Covers prenatal services and birthing services rendered in a licensed birthing center. CHIP Perinate Newborn Members: Covers services rendered to a newborn immediately following delivery.	Covers prenatal services and birthing services rendered in a licensed birthing center. Prenatal services subject to the following limitations: Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) one (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (0) weeks from 28 to 36 weeks of pregnancy; and

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
		(3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 Days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: ▪ interim history (problems, marital status, fetal status); ▪ physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and ▪ laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: ▪ Orthotic braces and orthotics ▪ Dental devices	Not a covered benefit, with the exception of a limited set of disposable medical supplies, and only when they are obtained from a CHIP-enrolled pharmacy provider.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses ▪ Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease ▪ Hearing aids ▪ Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)	
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies. ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker ▪ Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services ▪ Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: ▪ Neuropsychological and psychological testing. ▪ When inpatient psychiatric services are ordered: 1) by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapter D: or 0) as a condition of probation. The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2. ▪ Does not require PCP referral	Not a covered benefit.
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	• Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development) ▪ When outpatient psychiatric services are ordered ▪ 1) by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters B and C, or 574, Subchapters A through G, Texas Family Code Chapter 55, Subchapter D:, or 2)as a condition of probation ▪ The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 Tex. Admin. Code., §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), M and family education, and crisis services ▪ Does not require PCP referral	
Inpatient and Residential Substance Abuse Treatment Services	Services include, but are not limited to: ▪ Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs ▪ When inpatient and residential substance use disorder treatment services are required as: ▪ 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code;, or ▪ 2) as a condition of probation ▪ The court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2 ▪ Does not require PCP referral	
Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following: ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per Day ▪ Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training ▪ When outpatient substance use disorder treatment services are required as: ▪ 1) a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code;, or ▪ 2) as a condition of probation the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. ▪ These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2.Does not require PCP referral	Not a covered benefit.
Rehabilitation Services	Services include, but are not limited to, the following: ▪ Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: ▪ Physical, occupational and speech therapy ▪ Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: ▪ Palliative care, including medical and support services, for those children who have six (6) months or less to live, to keep Members comfortable during the last weeks and months before death	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	▪ Treatment services, including treatment related to the terminal illness ▪ Up to a maximum of 120 Days with a 6 month life expectancy ▪ Members electing hospice services may cancel this election at anytime ▪ Services apply to the hospice diagnosis	
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	MCO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Hospital emergency department room and ancillary services and physician services 24 hours a Day, seven (7) Days a week, both by in-network and out-of- network providers ▪ Medical screening examination ▪ Stabilization services ▪ Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services ▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin.	MCO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. ▪ Emergency services based on prudent lay person definition of emergency health condition ▪ Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. ▪ Stabilization services related to the labor with delivery of the covered unborn child. ▪ Emergency ground, air and water transportation for labor and threatened labor is a covered benefit ▪ Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses.	Not a covered benefit.

Covered Benefit	CHIP Members and CHIP Perinate Newborn Members	CHIP Perinate Members (Unborn Child)
	Services include: ▪ One (1) examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization ▪ One (1) pair of non-prosthetic eyewear per 12-month period	
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12-month period limit for a plan- approved program ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Drug Benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting. Services must be medically necessary for the unborn child.

CHIP EXCLUSIONS FROM COVERED SERVICES

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning)
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of Member, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters Band C, 574, Subchapter D or 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Dental devices solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care, and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section, and services provided by an FQHC, as provided for in Section 8.1.22 of the Contract.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet

preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa)

EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, when they are obtained from an authorized pharmacy provider.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.

- Medical transportation not directly related to labor or threatened labor, miscarriage or nonviable pregnancy, and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of Member, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child and services provided by an FQHC, as provided in Section 8.1.22 of the Contract.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
- Medications prescribed for weight loss or gain
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Over-the-counter medications
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services

- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

CHIP DME/SUPPLIES

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members (Unborn Child), with the exception of a limited set of disposable medical supplies, when they are obtained from an authorized pharmacy provider.

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by Members highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
			kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for Members with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 Days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For Members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan

SUPPLIES	COVERED	EXCLUDED	COMMENTS / MEMBER CONTRACT PROVISIONS
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.