X. ENROLLMENT PERIOD FAMILY COPAYMENT MAXIMUM

Under this plan, there is a limit per family on the Co-payments that YOU must pay for Covered Health Services each enrollment period. It is YOUR responsibility to keep up with how much YOU have paid for Covered Health Services and to provide proof to CHIP. CHIP will notify YOU of the amount of YOUR Co-payment maximum and will provide YOU with a simplified form that YOU can use to keep up with the amount of Co-payments that YOU have paid.

YOU must notify CHIP when the maximum Co-payment under the Plan has been paid. When YOU notify CHIP about reaching the Co-payment maximum, CHIP will issue a new Member ID Card for each CHILD in YOUR family. The new Member ID Card will notify participating Physicians and providers to waive Co-payments for the remainder of the enrollment period for the CHILD.

XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

These health services when medically necessary must be furnished in the most appropriate and least restrictive setting in which services can be safely provided; must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the Member's physical health or the quality of life.

Emergency Care is a covered CHIP service and must be provided in accordance with **Section VII. D. Emergency Services**. Please refer to **Section II Definitions**, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an Emergency Condition exists.

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-payments apply until a family reaches its specific enrollment period co-payment maximum. Co-payments do not apply to preventive services or pregnancy-related assistance.

Covered Benefit		Limitations	Co-payments*
Inpatient General Acute and	•	Requires authorization for non-	\$35 inpatient
Inpatient Rehabilitation		Emergency Care and care	co-payment per
Hospital Services		following stabilization of an	admission.
hospital bel vices		Emergency Condition.	
Services include:		Requires authorization for in-	
 Hospital-provided Physician or 	_	network or out-of-network	
Provider services		facility and Physician services	
 Semi-private room and board 		for a mother and her	
(or private if medically		newborn(s) after 48 hours	
necessary as certified by		following an uncomplicated	
attending)		vaginal delivery and after 96	
 General nursing care 		0	
•		hours following an uncomplicated delivery by	
opeolar daty haroling the		caesarian section.	
medically necessaryICU and services		Caesalian Section.	
ratione model and special diete			
 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 patient 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			
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	Covered Benefit	Limitations	Co-payments*
	for a mother and her	Limitations	00-payments
	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:		
	- dilation and curettage (D&C)		
	procedures;		
	 appropriate provider- administered mediactions. 		
	administered medications;		
	 ultrasounds; and bistological examination of 		
	 histological examination of tissue samples. 		
	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 condition and/or		
	tumor growth or its		
-	treatment.		
-	Surgical implants		
-	Other artificial aids including		

Covered Benefit	Limitations	Co-payments*
surgical implants		
 Inpatient services for a 		
mastectomy and breast		
reconstruction include:		
 all stages of reconstruction 		
on the affected breast;		
 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.		
Skilled Nursing	 Requires authorization and 	None
Facilities	physician prescription	
(Includes Rehabilitation	 60 days per 12-month period 	
Hospitals)	limit.	
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 		
appliances and equipment		
furnished by the facility Outpatient Hospital,	 May require prior authorization 	
Comprehensive Outpatient	 May require prior authorization and physician prescription 	¢0 co povront
Rehabilitation Hospital, Clinic	and physician prescription	\$0 co-payment for generic
(Including Health Center) and		drugs.
Ambulatory Health Care Center		\$5 co-payment
		for brand drugs.
Services include, but are not		J
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 tosts (taskning) component) 		
tests (technical component)		<u> </u>
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	Covered Benefit	Limitations	Co-payments*
	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		
-	Respiratory services		
-	Radiation and chemotherapy		
-	Blood or blood products that are		
	not provided free-of-charge to		
	the patient and the		
	administration of these products		
-	Facility and related medical		
	services, such as anesthesia,		
	associated with dental care,		
	when provided in a licensed		
	ambulatory surgical facility.		
-	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.		
•	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:		

Covered Benefit Limitations Co-pa	ayments*
- 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.	
 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;	
- 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.	
	payment
Extender Professional Servicesspecialty servicesfor off	ice visit.
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, in-patient and outpatient convisos 	
and outpatient services CHIP-EOC -11 28 18-Schedule A	6

Covered Benefit	Limitations	Co-payments*
 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;		
 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		
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Covered Benefit	Limitations	Co-payments*
an uncomplicated vaginal		
delivery and 96 hours following		
an uncomplicated delivery by		
caesarian section.		
 Physician services medically 		
necessary to support a dentist		
providing dental services to a		
CHIP member such as general		
anesthesia or intravenous (IV)		
sedation.		
 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.		
 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.		
Birthing Center Services	Covers birthing services provided	None
-	by a licensed birthing center.	
	Limited to facility services (e.g.,	

Covered Benefit	Limitations	Co-payments*
	labor and delivery)	
Services rendered by a Certified	Covers prenatal, birthing, and	None.
Nurse Midwife or physician in a	postpartum services rendered in a	
licensed birthing center.	licensed birthing center.	
Durable Medical Equipment	 May require prior authorization 	None
	and physician prescription	
 (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that 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 but not limited to: Orthotic braces and orthotics Dental Devices Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease Other artificial aids including surgical implants Hearing aids Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed 		
specialty formula and dietary		
supplements.	Dequires prior sutherization and	Nono
Home and Community Health	 Requires prior authorization and physician proscription 	None
Services	physician prescription	0

 Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker. 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. Inpatient 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 psychiatric services are ordered 1) by a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapter D: or 2) as a condition of probation. The court order serves as binding determination of services must be presented to the court with jurisdiction over the matter for determination of services must be presented to 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 	Covered Benefit	Limitations	Co-payments*
 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 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 	 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 	 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 	
	 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 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 	non-emergency services	

Covered Benefit	Limitations	Co-payments*
considered incarcerated, as		
defined by UMCM Section		
16.1.15.2.		
Outpatient Mental Health	 May require prior authorization. 	\$5 co-payment
Services	 Does not require PCP referral. 	for office visit.
	 A Qualified Mental Health 	
Mental health services, including	Provider – Community Services	
for serious mental illness, provided	(QMHP-CS), is defined by the	
on an outpatient basis, including,	Texas Department of State	
but not limited to:	Health Services (DSHS) in Title	
The visits can be furnished in a	25 Tex. Admin. Code	
variety of community-based	§412.303(48). QMHP-CSs shall	
settings (including school and	be providers working through a	
home-based) or in a state-	DSHS-contracted Local Mental	
operated facility.	Health Authority or a separate	
 Neuropsychological and 	DSHS-contracted entity. QMHP-	
psychological testing	CSs shall be supervised by a	
 Medication management 	licensed mental health	
 Residential treatment services 	professional or physician and	
 Sub-acute outpatient services 	provide services in accordance	
(partial hospitalization or	with DSHS standards. Those	
rehabilitative day treatment)	services include individual and	
 Skills training (psycho- 	group skills training (that can be	
educational skill development	components of interventions	
 When outpatient psychiatric 	such as day treatment and in-	
services are ordered 1) by a	home services), patient and	
court of competent jurisdiction	family education, and crisis	
pursuant to the Texas Health	services.	
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.		
Inpatient and Residential	 Requires prior authorization for 	\$35 inpatient
		+ 30pationt

Covered Benefit	Limitations	Co-payments*
Substance Abuse Treatment	non-emergency services	co-payment.
Services	 Does not require PCP referral. 	
 Services Inpatient and substance abuse treatment 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: a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 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.	
Outpatient Substance Abuse	 Requires prior authorization. 	\$5 co-payment
Treatment Services	 Does not require PCP referral. 	for office visit.
 Outpatient substance abuse treatment services include, but are not limited to: 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 		
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Covered Benefit	Limitations	Co-payments*
 Covered Benefit Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that 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: a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or as a condition of probation the court order serves as a binding determination 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 	Limitations	Co-payments*
defined by UMCM Section 16.1.15.2. Rehabilitation Services	 Requires prior authorization and 	None
 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 	physician prescription	

Covered Benefit	Limitations	Co-payments*
 Hospice Care Services Services include, but are not limited to: Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during_the last weeks and months before death Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. 	 Requires authorization and physician prescription Services apply to the hospice diagnosis. Up to a maximum of 120 days with a 6 month life_expectancy. Patients electing hospice may cancel this election at anytime. 	None
 Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: 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, 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 dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal 	 Does not require authorization for post-stabilization services 	\$5 co-payment for non- emergency ER.
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Covered Benefit	Limitations	Co-payments*
of cysts		
Transplants	Requires authorization	None
 Covered services include: 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. 		
 Vision Benefit Covered services include: One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period 	 The health plan may reasonably limit the cost of the frames/lenses. May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	\$5 co-payment for office visit.
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation	 Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) Requires authorization for additional visits. 	\$5 co-payment for office visit.
Tobacco Cessation Program Covered up to \$100 for a 12- month period limit for a plan- approved program	 Requires authorization Health Plan defines plan- approved program. May be subject to formulary requirements. 	None
Value-Added Services		
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Extra Help with Getting a Ride	A free ride service to help you get to doctor visits or health education classes.	None

Covered Benefit	Limitations	Co-payments*
Dental Services	Pregnant members 21 or older can receive up to \$500 each year for dental checkups, x- rays, routine cleaning, fillings, and extractions.	None
Discount Pharmacy / Over-the-Counter Benefits	\$25 gift packet which includes a first aid kit and a \$10 Walmart gift card for health related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	None
Sports and school physicals	Members between the ages of 4 through18 can get a free physical for sports each year.	None
Help for Members with Asthma	One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	None
	Pregnant members can receive:	
Extra Help for Pregnant Women	A free convertible car seat after attending a baby shower at El Paso Health;	None
	Gift cards for completing prenatal visits and after confirmation of those visits for:	
	 \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - flu shot during pregnancy, \$25 -a timely postpartum visit within 21- 56 days of delivery. 	
	A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	
Health and Wellness Services	Members age 18 or younger can receive four additional nutritional/obesity counseling services above the CHIP benefit.	None
Gift Programs	A \$15 gift card is offered to members ages 3-6 and 12-19 who get a check-up when due and on time.	None
	The First-Steps program offers Baby Shower gifts and a convertible car seat.	
	Gift cards are offered for completion of specific activities related to your pregnancy and delivery. The gift card awards are given	

for the following:• \$25 - Prenatal visit in the first trimester or within 42 days of enrollment,• \$20 - 3rd prenatal visit,• \$20 - 3rd prenatal visit,• \$20 - 6th prenatal visit,• \$20 - 9th prenatal visit,• \$20 - a flu shot during pregnancy,• \$25 - a timely postpartum visit within 21- 56 days of delivery.Inpatient Follow -up Incentive ProgramA \$10 movie gift card is offered to members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a	Covered Benefit	Limitations	Co-payments*
behavioral health inpatient hospital stay. Members can receive one movie gift card per year.		 for the following: \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - a flu shot during pregnancy, \$25 - a timely postpartum visit within 21- 56 days of delivery. A \$10 movie gift card is offered to members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one movie gift card 	

* Co-payments do not apply to preventive services or pregnancy-related assistance.

EXCLUSIONS

- 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 patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- 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.
- Dental devices solely for cosmetic purposes
- 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
- 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
- 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 (routine foot care does not include treatment of injury or complications of diabetes).
- 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, that 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).

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER
	D	D	CONTRACT PROVISIONS
Ace Bandages		Х	Exception: If provided by and billed through
			the clinic or home care agency it is covered as
			an incidental supply.
Alcohol, rubbing		Х	Over-the-counter supply.
Alcohol, swabs	Х		Over-the-counter supply not covered, unless
(diabetic)			RX provided at time of dispensing.
Alcohol, swabs	Х		Covered only when received with IV therapy or
			central line kits/supplies.
Ana Kit	Х		A self-injection kit used by patients highly
Epinephrine			allergic to bee stings.
Arm Sling	Х		Dispensed as part of office visit.
Attends	Х		Coverage limited to children age 4 or over only
(Diapers)			when prescribed by a physician and used to
			provide care for a covered diagnosis as
			outlined in a treatment care plan
Bandages		Х	
Basal		Х	Over-the-counter supply.
Thermometer			

DME/SUPPLIES

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
Batteries – initial	Х		For covered DME items
Batteries –	Х		For covered DME when replacement is
replacement			necessary due to normal use.
Betadine		Х	See IV therapy supplies.
Books		Х	
Clinitest	Х		For monitoring of diabetes.
Colostomy Bags		X	See Ostomy Supplies.
Communication Devices		Х	
Contraceptive Jelly		Х	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		Х	
Dental Devices	Х		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	Х		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/ Incontinent Briefs/Chux	Х		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		Х	Contraceptives are not covered under the plan.
Diastix	Х		For monitoring diabetes.
Diet, Special		Х	
Distilled Water		Х	
Dressing Supplies/ Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/ Decubitus	Х		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Periph eral IV Therapy	Х		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		Х	
Dust Mask		Х	
Ear Molds	Х		Custom made, post inner or middle ear surgery
Electrodes	Х		Eligible for coverage when used with a covered DME.

SUPPLIES	COVERE D	EXCLUDE	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		 X	Over-the-counter supply.
Enteral Nutrition Supplies	Х		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	Х		Covered for patients 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 <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
Gloves		Х	Exception: Central line dressings or wound
			care provided by home care agency.
Hydrogen Peroxide		Х	Over-the-counter supply.
Hygiene Items		Х	
Incontinent Pads	Х		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	Х		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	Х		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	Х		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		Х	Over-the-counter supply.
Lancet Device	Х		Limited to one device only.
Lancets	Х		Eligible for individuals with diabetes.
Med Ejector	Х		
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	Х		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	×		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	Х		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
			nutrition.
Saline, Normal	Х		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	Х		
Stump Socks	Х		
Suction	Х		
Catheters			
Syringes			See Needles/Syringes.
Таре			See Dressing Supplies, Ostomy Supplies, IV
-			Therapy Supplies.
Tracheostomy	Х		Cannulas, Tubes, Ties, Holders, Cleaning Kits,
Supplies			etc. are eligible for coverage.
Under Pads	X		See Diapers/Incontinent Briefs/Chux.
Unna Boot	Х		Eligible for coverage when part of wound care in the home setting. Incidental charge when
			applied during office visit.
Urinary,		Х	Exception: Covered when used by incontinent
External		Λ	male where injury to the urethra prohibits use
Catheter &			of an indwelling catheter ordered by the PCP
Supplies			and approved by the plan
Urinary,	Х		Cover catheter, drainage bag with tubing,
Indwelling			insertion tray, irrigation set and normal saline
Catheter &			if needed.
Supplies			
Urinary,	Х		Cover supplies needed for intermittent or
Intermittent			straight catherization.
Urine Test Kit	Х		When determined to be medically necessary.
Urostomy			See Ostomy Supplies.
supplies			

X. ENROLLMENT PERIOD FAMILY COPAYMENT MAXIMUM

Under this plan, there is a limit per family on the Co-payments that YOU must pay for Covered Health Services each enrollment period. It is YOUR responsibility to keep up with how much YOU have paid for Covered Health Services and to provide proof to CHIP. CHIP will notify YOU of the amount of YOUR Co-payment maximum and will provide YOU with a simplified form that YOU can use to keep up with the amount of Co-payments that YOU have paid.

YOU must notify CHIP when the maximum Co-payment under the Plan has been paid. When YOU notify CHIP about reaching the Co-payment maximum, CHIP will issue a new Member ID Card for each CHILD in YOUR family. The new Member ID Card will notify participating Physicians and providers to waive Co-payments for the remainder of the enrollment period for the CHILD.

XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

These health services when medically necessary must be furnished in the most appropriate and least restrictive setting in which services can be safely provided; must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the Member's physical health or the quality of life.

Emergency Care is a covered CHIP service and must be provided in accordance with **Section VII. D. Emergency Services**. Please refer to **Section II Definitions**, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an Emergency Condition exists.

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-payments apply until a family reaches its specific enrollment period co-payment maximum. Co-payments do not apply to preventative services or pregnancy-related assistance.

Covered Benefit		Limitations	Co-payments*
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	■	Requires authorization for non- Emergency Care and care following stabilization of an Emergency Condition.	\$75 inpatient co- payment per admission.
 Services include: 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 		Requires authorization for in- network or out-of-network facility and Physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by	

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Covered Benefit	Limitations	Co-payments*
medically necessary	caesarian section.	
 ICU and services 		
 Patient 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 patient 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,		

Schedule B

Covered Benefit	Limitations	Co-payments*
or a fetus that expired in		
utero.) 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. 		
 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.		
 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;		
 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.Requires authorization and physician prescriptionSkilled Nursing Facilities (Includes Rehabilitation Hospitals)• Requires authorization and physician prescriptionNoneServices include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Medical supplies and use of appliances and equipment furnished by the facility• May require prior authorization and physician prescription\$10 cc for ge drugs, \$35 cc for braOutpatient Hospital, (Including Health Center) hospital (Dinic (Including Health Center) compatibilitor 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 • Drugs, medications and biologicals• May require prior authorization and physician prescription• May require prior authorization and physician prescription\$10 cc for ge drugs, \$35 cc for bra	Covered Benefit	Limitations	Co-payments*
count towards the DME 12 month period limit.Requires authorization and physician prescriptionSkilled Nursing Facilities (Includes Rehabilitation Hospitals)• Requires authorization and physician prescriptionNoneServices include, but are not limited to, the following: • Semi-private room and board • Repalar nursing services • Medical supplies and use of appliances and equipment furnished by the facility• May require prior authorization and physician prescription\$10 cc for ge drugs.Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center• May require prior authorization and physician prescription\$10 cc for ge drugs.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)• May require prior authorization and physician prescription• Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals• May require prior authorization and physician prescription	covered under Inpatient and		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals) • Requires authorization and physician prescription None Services include, but are not limited to, the following: • 60 days per 12-month period limit. None Services include, but are not limited to, the following: • 60 days per 12-month period limit. None • Semi-private room and board • Repular nursing services • Medical supplies and use of appliances and equipment furnished by the facility • May require prior authorization and physician prescription \$10 cc for ge drugs. Outpatient Hospital, (Including Health Certer) and Ambulatory Health Care Center • May require prior authorization and physician prescription \$10 cc for ge drugs. 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: • May require prior authorization and physician prescription • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • May require prior authorization and physician prescription	count towards the DME 12		
(Includes Rehabilitation Hospitals)60 days per 12-month period limit.Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Medical supplies and use of appliances and equipment furnished by the facility• May require prior authorization and physician prescriptionOutpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center• May require prior authorization and physician prescriptionServices 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)• Maxima and physician prescription• Laboratory and pathology services • Drugs, medications and biologicals• May require prior authorization and physician prescription		 Requires authorization and 	None
Hospitals)limit.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 facilityIimit.Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center• May require prior authorization and physician prescriptionServices 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 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 Drugs, medications and biologicals 		5 1 1	
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care CenterMay require prior authorization and physician prescription\$10 cd for ge drugs. \$35 cd for bradenServices 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:• May require prior authorization and physician prescription\$10 cd for ge drugs. \$35 cd for braden• X-ray, imaging, and radiological tests (technical component)• X-ray, imaging, and radiological tests (technical component)• Ambulatory surgical facility services• Drugs, medications and biologicals	mited to, the following: Semi-private room and board Regular nursing services Rehabilitation services Medical supplies and use of appliances and equipment		
Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Centerand physician prescription\$10 cd for ge drugs.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 servicesDrugs, medications and biologicals and physician prescription\$10 cd 		 May require prior authorization 	
•	ehabilitation Hospital, Clinic Including Health Center) and mbulatory Health Care Center ervices include, but are not mited to, the following services rovided in a hospital clinic or mergency room, a clinic or health enter, hospital-based emergency epartment or an ambulatory ealth 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	and physician prescription	\$10 co-payment for generic drugs. \$35 co-payment for brand drugs.
 Casts, splints, dressings Preventive health services Physical, occupational and speech therapy Renal dialysis Respiratory services Radiation and chemotherapy Blood or blood products that 	Casts, splints, dressings Preventive health services Physical, occupational and speech therapy Renal dialysis Respiratory services Radiation and chemotherapy		

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	Covered Benefit	Limitations	Co-navments*
	are not provided free-of-charge	Limitations	Co-payments*
	to the patient and the		
	administration of these		
_	products		
•	Facility and related medical		
	services, such as anesthesia,		
	associated with dental care,		
	when provided in a licensed		
_	ambulatory surgical facility.		
•	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.		
•	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.		
	Surgical implants		
-	Other artificial aids including		
-	surgical implants		
	Outpatient services provided at		
-	outpatient services provided at		

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	Covered Benefit	Limitations	Co-payments*
	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;		
	- 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.		
	ysician/Physician	May require authorization for	\$20 co-payment
Ех	tender Professional Services	specialty services	for office visit.
	rvices include, but are not		
•	hited 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, in-patient		
	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 		

Covered Benefit	Limitations	Co-payments*
surgeons for surgical		
procedures including		
appropriate follow-up ca		
 Administration of anest 	nesia	
by Physician (other thai	ר	
surgeon) or CRNA		
 Second surgical opinion 	S	
 Same-day surgery 		
performed in a Hospital		
without an over-night s	tay	
 Invasive diagnostic 		
procedures such as		
endoscopic examinatior	IS	
 Hospital-based Physician 		
services (including Physicia	in-	
performed technical and		
interpretive components)		
 Physician and professional 		
services for a mastectomy		
breast reconstruction inclue		
 all stages of reconstruct 	tion	
on the affected breast;		
 surgery and reconstruct 	ion	
on the other breast to		
produce symmetrical		
appearance; and		
- treatment of physical		
complications from the		
mastectomy and treatm	ient	
of lymphedemas.		
 In-network and out-of-network 		
Physician services for a mo	other	
and her newborn(s) for a		
minimum of 48 hours follow	wing	
an uncomplicated vaginal		
delivery and 96 hours follo	5	
an uncomplicated delivery	бу	
caesarian section.		
 Physician services medicall 	5	
necessary to support a der		
providing dental services to		
CHIP member such as gene		
anesthesia or intravenous	(IV)	
sedation.		
 Physician services associat with (a) misservices as (b) 		
with (a) miscarriage or (b)		
non-viable pregnancy (mol	ar	

Covered Benefit	Limitations	Co-payments*
 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. 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. 		CO-payments.
Birthing Center Services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)	None
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center.	None.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a	 May require prior authorization and physician prescription \$20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this 	None

Covered Benefit	Limitations	Co-payments*
medical purpose, generally is not	cap).	
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 but not limited to:		
 Orthotic braces and orthotics 		
 Dental Devices 		
 Prosthetic devices such as 		
artificial eyes, limbs, braces,		
and external breast prostheses		
 Prosthetic eyeglasses and 		
contact lenses for the		
management of severe		
ophthalmologic disease		
 Other artificial aids including 		
surgical implants		
 Hearing aids 		
 Implantable devices are 		
covered under Inpatient and		
Outpatient services and do not		
count towards the DME 12-		
month period limit.Diagnosis-specific disposable		
 Diagnosis-specific disposable medical supplies, including 		
diagnosis-specific prescribed		
specialty formula and dietary		
supplements.		
Home and Community Health	 Requires prior authorization and 	None
Services	physician prescription	None
	 Services are not intended to 	
Services that are provided in the	replace the CHILD'S caretaker	
home and community, including,	or to provide relief for the	
but not limited to:	caretaker.	
 Home infusion 	 Skilled nursing visits are 	
 Respiratory therapy 	provided on intermittent level	
 Visits for private duty nursing 	and not intended to provide 24-	
(R.N., L.V.N.)	hour skilled nursing services.	
 Skilled nursing visits as defined 	 Services are not intended to 	
for home health purposes (may	replace 24-hour inpatient or	
include R.N. or L.V.N.).	skilled nursing facility services.	
Home health aide when		

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Covered Benefit	Limitations	Co-payments*
 included as part of a plan of care during a period that skilled visits have been approved. Speech, physical and occupational therapies. Inpatient Mental Health 	 Requires prior authorization for 	\$75 inpatient co-
 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 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 	 non-emergency services Does not require PCP referral. 	payment.
16.1.15.2. 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	 May require prior authorization. Does not require PCP referral. 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 	\$20 co-payment for office visit.

	Covered Benefit		Limitations	Co-payments*
•	variety of community-based settings (including school and home-based) or in a state- operated facility. Neuropsychological and psychological testing Medication management 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 B and C, or 574, 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.		Limitations \$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 (that can be components of interventions such as day treatment and in- home services), patient and family education, and crisis services.	Co-payments*
	These requirements are not applicable when the Member is considered incarcerated, as defined by UMCM Section 16.1.15.2.			
	patient and Residential Ibstance Abuse Treatment	•	Requires prior authorization for non-emergency services	\$75 inpatient co- payment.
Se	ervices	•	Does not require PCP referral.	
tre	patient and substance abuse eatment services include, but are t limited to: Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24- hour residential rehabilitation			

Covered Benefit	Limitations	Co-payments*
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 		
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.		
Outpatient Substance Abuse	 Requires prior authorization. 	\$20 co-payment
Treatment Services	 Does not require PCP referral. 	for office visit.
Outpatient substance abuse		
Outpatient substance abuse treatment services include, but are		
not limited to:		
 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 that		
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 		
uenneu as consisting of at least		

Covered Benefit	Limitations	Co-payments*
 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: a court order, consistent with Chapter 462, Subchapter of the Texas Health and Safety Code; or 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. 		oo-payments
 Rehabilitation Services 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 	 Requires prior authorization and physician prescription 	None
 Hospice Care Services Services include, but are not limited to: Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during_the last weeks and months before 	 Requires authorization and physician prescription Services apply to the hospice diagnosis. Up to a maximum of 120 days with a 6 month life_expectancy. Patients electing hospice services may cancel this election at anytime. 	None

Co-pay Level 2 - Above 151% up to and including 186% of FPL

Covered Benefit	Limitations	Co-payments*
 death Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. 		
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	 Does not require authorization for post-stabilization services 	\$75 co-payment for non- emergency ER.
 Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: 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, 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, and removal of cysts 		
Transplants	 Requires authorization 	None
 Covered services include: Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone 		

Covered Benefit	Limitations	Co-payments*
marrow and peripheral stem		
cell transplants, including donor		
medical expenses. Vision Benefit	 The health plan may reasonably 	\$20 co-payment
 Covered services include: One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period 	 The health plan may reasonably limit the cost of the frames/lenses. May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	for office visit.
Chiropractic Services Covered services do not require physician prescription and are limited to spinal subluxation	 Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) Requires authorization for additional visits. 	\$20 co-payment for office visit.
Tobacco Cessation Program Covered up to \$100 for a 12- month period limit for a plan- approved program	 May require authorization Health Plan defines plan- approved program. May be subject to formulary requirements. 	None
Value-Added Services		
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Extra Help with Getting a Ride	A free ride service to help you get to doctor visits or health education classes.	None
Dental Services	Pregnant members 21 or older can receive up to \$500 each year for dental checkups, x-rays, routine cleaning, fillings, and extractions.	None
Discount Pharmacy / Over-the-Counter Benefits	\$25 gift packet which includes a first aid kit and a \$10 Walmart gift card for health related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	None
Sports and school physicals	Members between the ages of 4 through18	None

Covered Benefit	Limitations	Co-payments*
	can get a free physical for sports each year.	
Help for Members with Asthma	One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	None
	Pregnant members can receive:	
Extra Help for Pregnant Women	A free convertible car seat after attending a baby shower at El Paso Health;	None
	Gift cards for completing prenatal visits and after confirmation of those visits for:	
	 \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - flu shot during pregnancy, \$25 -a timely postpartum visit within 21- 56 days of delivery. A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	
Health and Wellness Services	Members age 18 or younger can receive four additional nutritional/obesity counseling services above the CHIP benefit.	None
Gift Programs	A \$15 gift card is offered to members ages 3-6 and 12-19 who get a check-up when due and on time.	None
	The First-Steps program offers Baby Shower gifts and a convertible car seat.	
	Gift cards are offered for completion of specific activities related to your pregnancy and delivery. The gift card awards are given for the following:	
	 \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - a flu shot during pregnancy, \$25 - a timely postpartum visit within 21- 56 days of delivery. 	
Inpatient Follow -up Incentive Program	A \$10 movie gift card is offered to members	None

Covered Benefit	Limitations	Co-payments*
	20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one movie gift card per year.	

*Co-payments do not apply to preventive services or pregnancy-related assistance.

EXCLUSIONS

- 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 patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- 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.
- Dental devices solely for cosmetic purposes
- 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
- 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
- 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 (routine foot care does not include treatment of injury or complications of diabetes).
- 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

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Co-pay Level 2 - Above 151% up to and including 186% of FPL

- 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, that 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).

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER
	D	D	CONTRACT PROVISIONS
Ace Bandages		Х	Exception: If provided by and billed through
			the clinic or home care agency it is covered as
			an incidental supply.
Alcohol, rubbing		Х	Over-the-counter supply.
Alcohol, swabs	Х		Over-the-counter supply not covered, unless
(diabetic)			RX provided at time of dispensing.
Alcohol, swabs	Х		Covered only when received with IV therapy or
			central line kits/supplies.
Ana Kit	Х		A self-injection kit used by patients highly
Epinephrine			allergic to bee stings.
Arm Sling	Х		Dispensed as part of office visit.
Attends	Х		Coverage limited to children age 4 or over only
(Diapers)			when prescribed by a physician and used to
			provide care for a covered diagnosis as
			outlined in a treatment care plan
Bandages		Х	
Basal		Х	Over-the-counter supply.
Thermometer			

DME/SUPPLIES

SUPPLIES	COVERE D	EXCLUDE	COMMENTS/MEMBER CONTRACT PROVISIONS
Batteries –	X	U	For covered DME items
initial	~	•	TO COVERED DIVIE ITEMS
Batteries –	Х		For covered DME when replacement is
replacement			necessary due to normal use.
Betadine		Х	See IV therapy supplies.
Books		Х	
Clinitest	Х		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication		Х	
Devices			
Contraceptive		Х	Over-the-counter supply. Contraceptives are
Jelly			not covered under the plan.
Cranial Head		Х	
Mold			
Dental Devices	Х		Coverage limited to dental devices used for the
			treatment of craniofacial anomalies, requiring
	X		surgical intervention.
Diabetic	Х		Monitor calibrating solution, insulin syringes,
Supplies			needles, lancets, lancet device, and glucose strips.
Diapers/	Х		Coverage limited to children age 4 or over only
Incontinent	~		when prescribed by a physician and used to
Briefs/Chux			provide care for a covered diagnosis as
			outlined in a treatment care plan
Diaphragm		Х	Contraceptives are not covered under the plan.
Diastix	Х		For monitoring diabetes.
Diet, Special		Х	<u> </u>
Distilled Water		Х	
Dressing	Х		Syringes, needles, Tegaderm, alcohol swabs,
Supplies/Centra			Betadine swabs or ointment, tape. Many times
I Line			these items are dispensed in a kit when
			includes all necessary items for one dressing
			site change.
Dressing	Х		Eligible for coverage only if receiving covered
Supplies/			home care for wound care.
Decubitus	N N		Eligible for equerage only if reaching have a 11/
Dressing Supplies/	Х		Eligible for coverage only if receiving home IV
Supplies/ Peripheral IV			therapy.
Therapy			
Dressing		Х	
Supplies/Other			
Dust Mask		Х	
Ear Molds	Х		Custom made, post inner or middle ear surgery
Electrodes	Х		Eligible for coverage when used with a covered

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER
	D	D	CONTRACT PROVISIONS
			DME.
Enema Supplies		Х	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	Х		Covered for patients 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 <i>not</i> medically necessary, are not covered,

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER CONTRACT PROVISIONS
	D		regardless of whether these regular food
			products are taken orally or parenterally.
Gloves		Х	Exception: Central line dressings or wound
			care provided by home care agency.
Hydrogen		Х	Over-the-counter supply.
Peroxide			11.5
Hygiene Items		Х	
Incontinent	Х		Coverage limited to children age 4 or over only
Pads			when prescribed by a physician_and used to
			provide care for a covered diagnosis as
			outlined in a treatment care plan
Insulin Pump	Х		Supplies (e.g., infusion sets, syringe reservoir
(External)			and dressing, etc.) are eligible for coverage if
Supplies			the pump is a covered item.
Irrigation Sets,	Х		Eligible for coverage when used during covered
Wound Care			home care for wound care.
Irrigation Sets,	Х		Eligible for coverage for individual with an
Urinary	Х		indwelling urinary catheter.
IV Therapy	X		Tubing, filter, cassettes, IV pole, alcohol
Supplies			swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		Х	Over-the-counter supply.
Lancet Device	Х		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and	X		See Diabetic Supplies
Syringes/			
Diabetic			
Needles and			See IV Therapy and Dressing Supplies/Central
Syringes/IV and			Line.
Central Line			
Needles and	Х		Eligible for coverage if a covered IM or SubQ
Syringes/Other			medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	Х		
Ostomy	Х		Items eligible for coverage include: belt,
Supplies			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	Х		Necessary supplies (e.g., tubing, filters,
ומוכוונכומו	^		necessary supplies (e.y., tubiliy, liiters,

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
Nutrition/ Supplies			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	Х		
Stump Socks	Х		
Suction Catheters	Х		
Syringes			See Needles/Syringes.
Таре			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	Х		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	Х		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		Х	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
Urinary, Indwelling Catheter & Supplies	Х		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	Х		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	х		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

X. ENROLLMENT PERIOD FAMILY COPAYMENT MAXIMUM

Under this plan, there is a limit per family on the Co-payments that YOU must pay for Covered Health Services each enrollment period. It is YOUR responsibility to keep up with how much YOU have paid for Covered Health Services and to provide proof to CHIP. CHIP will notify YOU of the amount of YOUR Co-payment maximum and will provide YOU with a simplified form that YOU can use to keep up with the amount of Co-payments that YOU have paid.

YOU must notify CHIP when the maximum Co-payment under the Plan has been paid. When YOU notify CHIP about reaching the Co-payment maximum, CHIP will issue a new Member ID Card for each CHILD in YOUR family. The new Member ID Card will notify participating Physicians and providers to waive Co-payments for the remainder of the enrollment period for the CHILD.

XI. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

These health services when medically necessary must be furnished in the most appropriate and least restrictive setting in which services can be safely provided; must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the Member's physical health or the quality of life.

Emergency Care is a covered CHIP service and must be provided in accordance with **Section VII. D. Emergency Services**. Please refer to **Section II Definitions**, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an Emergency Condition exists.

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-payments apply until a family reaches its specific enrollment period co-payment maximum. Co-payments do not apply to preventive services or pregnancy-related assistance.

Covered Benefit		Limitations	Co-payments*
Inpatient General Acute and	•	Requires authorization for non-	\$125 inpatient
Inpatient Rehabilitation		Emergency Care and care	co-payment per
Hospital Services		following stabilization of an	admission.
		Emergency Condition.	
Services include:		Requires authorization for in-	
 Hospital-provided Physician or 		network or out-of-network	
Provider services		facility and Physician services	
 Semi-private room and board 		for a mother and her	
(or private if medically		newborn(s) after 48 hours	
necessary as certified by		following an uncomplicated	
attending)		vaginal delivery and after 96	
 General nursing care 		hours following an	
 Special duty nursing when 		uncomplicated delivery by	
medically necessary		caesarian section.	
 ICU and services 			
 Patient 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 a 	e		
not provided free-of-charge to			
the patient and their			
administration			
 X-rays, imaging and other 			
radiological tests (facility			
technical component)			
 Laboratory and pathology 			
services (facility technical			
component)			
 Machine diagnostic tests (EEG 	1		
EKGs, etc.)			
 Oxygen services and inhalation 			
therapy Radiation and chemotherapy			
 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			

	Covered Benefit	Limitations	Co-payments*
	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:		
	- dilation and curettage (D&C)		
	procedures;		
	- appropriate provider-		
	administered medications;		
	- ultrasounds; and		
	 histological examination of 		
	tissue samples.		
•	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.		
•	Surgical implants		
•	Other artificial aids including		

Covered Benefit	Limitations	Co-payments*
surgical implants		
 Inpatient services for a 		
mastectomy and breast		
reconstruction include:		
 all stages of reconstruction 		
on the affected breast;		
 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.		
Skilled Nursing	 Requires authorization and 	None
Facilities	physician prescription	
(Includes Rehabilitation	 60 days per 12-month period 	
Hospitals)	limit.	
Services include, but are not		
limited to, the following:		
 Semi-private room and board Degular purging convices 		
Regular nursing servicesRehabilitation services		
 Medical supplies and use of 		
appliances and equipment		
furnished by the facility		
Outpatient Hospital,	 May require prior authorization 	
Comprehensive Outpatient	and physician prescription	
Rehabilitation Hospital, Clinic		\$10 co-payment
(Including Health Center) and		for generic
Ambulatory Health Care Center		drugs.
		\$35 co-payment
Services include, but are not		for brand drugs.
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 tosts (tochnical component) 		
tests (technical component)		

	Covered Benefit	Limitations	Co-payments*
•	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		
-	Respiratory services		
-	Radiation and chemotherapy		
-	Blood or blood products that are		
	not provided free-of-charge to		
	the patient and the		
	administration of these products		
•	Facility and related medical		
	services, such as anesthesia,		
	associated with dental care,		
	when provided in a licensed		
	ambulatory surgical facility.		
•	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.		
•	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:		

	Covered Benefit	Limitations	Co-payments*
	- 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.		
	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;		
	 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.		# 0 F
	ysician/Physician	May require authorization for	\$25 co-payment for office visit.
EX	tender Professional Services	specialty services	TOF OFFICE VISIT.
50	rvices include, but are not		
	nited to the following:		
	American Academy of Pediatrics		
	recommended well-child exams		
	•		
	e e		
•			
	and preventive health services (including but not limited to vision and hearing screening and immunizations) Physician office visits, in-patient and outpatient services		

	Covered Benefit	Limitations	Co-payments*
	Laboratory, x-rays, imaging and		oo paymonto
	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;		
	- 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		

	Covered Benefit	Limitations	Co-payments*
	an uncomplicated vaginal		
	delivery and 96 hours following		
	an uncomplicated delivery by		
	caesarian section.		
-	Physician services medically		
	necessary to support a dentist		
	providing dental services to a		
	CHIP member such as general		
	anesthesia or intravenous (IV)		
	sedation.		
-	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.		
-	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.		
Bi	rthing Center Services	Covers birthing services provided	None
		by a licensed birthing center.	
		Limited to facility services (e.g.,	

Covered Benefit	Limitations	Co-payments*
	labor and delivery)	
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers prenatal, birthing, and postpartum services rendered in a	None.
 Nurse Midwife or physician in a licensed birthing center. Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies Covered services include DME (equipment that 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 but not limited to: Orthotic braces and orthotics Dental Devices Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease Other artificial aids including surgical implants Hearing aids Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. Diagnosis-specific disposable 	Covers prenatal, birthing, and	None
medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.		
Home and Community Health Services	 Requires prior authorization and physician prescription 	None

Covered Benefit	Limitations	Co-payments*
 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. 	
 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 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 	 Requires prior authorization for non-emergency services Does not require PCP referral. 	\$125 inpatient co-payment.

Covered Benefit	Limitations	Co-payments*
considered incarcerated, as		
defined by UMCM Section		
16.1.15.2.		
Outpatient Mental Health	 May require prior authorization. 	\$25 co-payment
Services	 Does not require PCP referral. 	for office visit.
	 A Qualified Mental Health 	
Mental health services, including	Provider – Community Services	
for serious mental illness, provided	(QMHP-CS), is defined by the	
on an outpatient basis, including,	Texas Department of State	
but not limited to:	Health Services (DSHS) in Title	
 The visits can be furnished in a 	25 Tex. Admin. Code	
variety of community-based	§412.303(48). QMHP-CSs shall	
settings (including school and	be providers working through a	
home-based) or in a state-	DSHS-contracted Local Mental	
operated facility.	Health Authority or a separate	
 Neuropsychological and 	DSHS-contracted entity. QMHP-	
psychological testing	CSs shall be supervised by a	
 Medication management 	licensed mental health	
Residential treatment services	professional or physician and	
Sub-acute outpatient services	provide services in accordance	
(partial hospitalization or	with DSHS standards. Those	
rehabilitative day treatment)	services include individual and	
 Skills training (psycho- advantional akill davalanment 	group skills training (that can be	
educational skill development	components of interventions	
 When outpatient psychiatric services are ordered 1) by a 	such as day treatment and in-	
services are ordered 1) by a court of competent jurisdiction	home services), patient and family education, and crisis	
pursuant to the Texas Health	services.	
and Safety Code Chapters 573,	301 11003.	
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.		
Inpatient and Residential	 Requires prior authorization for 	\$125 inpatient

Covered Benefit	Limitations	Co-payments*
Substance Abuse Treatment	non-emergency services	co-payment.
Services	 Does not require PCP referral. 	1 5
 Inpatient and substance abuse treatment 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: a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 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. 		
Outpatient Substance Abuse	 Requires prior authorization. Dees not require PCP referral 	\$25 co-payment
 Treatment Services Outpatient substance abuse treatment services include, but are not limited to: 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 	 Does not require PCP referral. 	for office visit.

Covered Benefit	Limitations	Co-payments*
 Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that 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: a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or as a condition of probation the court order serves as a binding determination 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. 		
 Rehabilitation Services 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 	 Requires prior authorization and physician prescription 	None

Covered Benefit Hospice Care Services	•	Limitations Requires authorization and	Co-payments*
 Services include, but are not limited to: Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during_the last weeks and months before death Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services 	•	physician prescription Services apply to the hospice diagnosis. Up to a maximum of 120 days with a 6 month life_expectancy. Patients electing hospice services may cancel this election at anytime.	None
 services. Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: 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, 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 dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal 		Requires authorization for post- stabilization services	\$75 co-payment for non- emergency ER.

Covered Benefit	Limitations	Co-payments*
of cysts		
Transplants	 Requires authorization 	None
 Covered services include: 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. 		
Vision Benefit	 The health plan may reasonably limit the cost of the 	\$25 co-payment
 Covered services include: One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period 	 limit the cost of the frames/lenses. May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	for office visit.
Chiropractic Services	 Requires authorization for 	\$25 co-payment
Covered services do not require physician prescription and are limited to spinal subluxation.	 twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) Requires authorization for additional visits. 	for office visit.
Tobacco Cessation	 May require authorization 	None
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. 	
Value-Added Services		
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Extra Help with Getting a Ride	A free ride service to help you get to doctor visits or health education classes.	None

Covered Benefit	Limitations	Co-payments*
Dental Services	Pregnant members 21 or older can receive up to \$500 each year for dental checkups, x- rays, routine cleaning, fillings, and extractions.	None
Discount Pharmacy / Over-the-Counter Benefits	\$25 gift packet which includes a first aid kit and a \$10 Walmart gift card for health related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	None
Sports and school physicals	Members between the ages of 4 through18 can get a free physical for sports each year.	None
Help for Members with Asthma	One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	None
	Pregnant members can receive:	
Extra Help for Pregnant Women	A free convertible car seat after attending a baby shower at El Paso Health;	None
	Gift cards for completing prenatal visits and after confirmation of those visits for:	
	 \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - flu shot during pregnancy, \$25 -a timely postpartum visit within 21- 56 days of delivery. 	
	A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	
Health and Wellness Services	Members age 18 or younger can receive four additional nutritional/obesity counseling services above the CHIP benefit.	None
Gift Programs	A \$15 gift card is offered to members ages 3-6 and 12-19 who get a check-up when due and on time.	None
	The First-Steps program offers Baby Shower gifts and a convertible car seat.	
	Gift cards are offered for completion of specific activities related to your pregnancy and delivery. The gift card awards are given	

 for the following: \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, 	ments*
 \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - a flu shot during pregnancy, \$25 - a timely postpartum visit within 21- 56 days of delivery. Inpatient Follow -up Incentive Program A \$10 movie gift card is offered to members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one movie gift card per year.	nents*

*Co-payments do not apply to preventive services or pregnancy-related assistance.

EXCLUSIONS

- 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 patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- 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.
- Dental devices solely for cosmetic purposes
- 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
- 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
- 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 (routine foot care does not include treatment of injury or complications of diabetes).
- 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

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Co-pay Level 3- Above 186% up to and including 201% of FPL

- 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, that 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)

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER
	D	D	CONTRACT PROVISIONS
Ace Bandages		Х	Exception: If provided by and billed through
			the clinic or home care agency it is covered as
			an incidental supply.
Alcohol, rubbing		Х	Over-the-counter supply.
Alcohol, swabs	Х		Over-the-counter supply not covered, unless
(diabetic)			RX provided at time of dispensing.
Alcohol, swabs	Х		Covered only when received with IV therapy or
			central line kits/supplies.
Ana Kit	Х		A self-injection kit used by patients highly
Epinephrine			allergic to bee stings.
Arm Sling	Х		Dispensed as part of office visit.
Attends	Х		Coverage limited to children age 4 or over only
(Diapers)			when prescribed by a physician and used to
			provide care for a covered diagnosis as
			outlined in a treatment care plan
Bandages		Х	
Basal		Х	Over-the-counter supply.
Thermometer			

DME/SUPPLIES

SUPPLIES	COVERE D	EXCLUDE	COMMENTS/MEMBER CONTRACT PROVISIONS
Batteries –	X		For covered DME items
initial			
Batteries –	Х		For covered DME when replacement is
replacement			necessary due to normal use.
Betadine		Х	See IV therapy supplies.
Books		Х	
Clinitest	Х		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		Х	
Contraceptive Jelly		Х	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		Х	
Dental Devices	Х		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	Х		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/ Incontinent Briefs/Chux	Х		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		Х	Contraceptives are not covered under the plan.
Diastix	Х		For monitoring diabetes.
Diet, Special		Х	
Distilled Water		Х	
Dressing Supplies/ Central Line	Х		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/ Decubitus	Х		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/ Peripheral IV Therapy	Х		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		Х	
Dust Mask		Х	
Ear Molds	Х		Custom made, post inner or middle ear surgery
Electrodes	Х		Eligible for coverage when used with a covered

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER
	D	D	CONTRACT PROVISIONS
			DME.
Enema Supplies		Х	Over-the-counter supply.
Enteral	Х		Necessary supplies (e.g., bags, tubing,
Nutrition			connectors, catheters, etc.) are eligible for
Supplies			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
Eve Detebas	V		malabsorption due to disease
Eye Patches Formula	Х	Х	Covered for patients with amblyopia.
Futtiula		^	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 desumanted erapherungsed mater
			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

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
			products are taken orally or parenterally.
Gloves		Х	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		Х	Over-the-counter supply.
Hygiene Items		Х	
Incontinent Pads	Х		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	Х		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	Х		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	Х		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	Х		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		Х	Over-the-counter supply.
Lancet Device	Х		Limited to one device only.
Lancets	Х		Eligible for individuals with diabetes.
Med Ejector	Х		
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	Х		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/	Х		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS	
Supplies			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	Х			
Stump Socks	Х			
Suction Catheters	Х			
Syringes			See Needles/Syringes.	
Таре			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.	
Tracheostomy Supplies	Х		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		Х	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	
Urinary, Indwelling Catheter & Supplies	Х		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.	
Urinary, Intermittent	Х		Cover supplies needed for intermittent or straight catherization.	
Urine Test Kit	Х		When determined to be medically necessary.	
Urostomy supplies			See Ostomy Supplies.	

X. SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES

These health services when medically necessary must be furnished in the most appropriate and least restrictive setting in which services can be safely provided; must be provided at the most appropriate level or supply of service that can safely be provided and that could not be omitted without adversely affecting the Member's physical health or the quality of life.

Emergency Care is a covered CHIP service and must be provided in accordance with **Section VII. D. Emergency Services**. Please refer to **Section II Definitions**, for the definition of "Emergency and Emergency Condition" and the definition of "Emergency Services and Emergency Care" to determine if an Emergency Condition exists.

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.

Covered Benefit	Limitations	Consumente
	 Requires authorization for non- 	Co-payments None
Inpatient General Acute and	•	NULLE
Inpatient Rehabilitation	Emergency Care and care following stabilization of an	
Hospital Services	5	
Sanviaas include.	Emergency Condition. Requires authorization for in-	
Services include:		
 Hospital-provided Physician or Provider services 	network or out-of-network	
	facility and Physician services for	
 Semi-private room and board (or private if modically) 	a mother and her newborn(s)	
(or private if medically	after 48 hours following an	
necessary as certified by	uncomplicated vaginal delivery	
attending)	and after 96 hours following an	
General nursing care Special duty pursing when	uncomplicated delivery by	
 Special duty nursing when mediaally necessary 	caesarian section.	
medically necessaryICU and services		
 Patient meals and special diets Operating recovery and other 		
 Operating, recovery and other treatment rooms 		
 Anesthesia and administration 		
 (facility technical component) Surgical dressings, travs, casts, 		
e al gloar al coollige, traje, caoto,		
splintsDrugs medications and		
Brags, modications and		
biologicalsBlood or blood products that are		
not provided free-of-charge to		
the patient 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)		
CHIP-EOC -11.28.18-Schedule D		2
Co-pay Level 0 - Native American/Native Alaskan		2
So puj Lever o Transe i merican/transe i naskan		

	Covered Depetit	Limitations	
	Covered Benefit	Limitations	Co-payments
	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:		
	 dilation and curettage (D&C) 		
	procedures;		
	- appropriate provider-		
	administered medications;		
	- ultrasounds; and		
	 histological examination of 		
_	tissue samples.		
-	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		
	0		
	e		
	•		
•	growth or its treatment. Surgical implants Other artificial aids including surgical implants Inpatient services for a mastectomy and breast		

CHIP-EOC -11.28.18-Schedule D Co-pay Level 0 - Native American/Native Alaskan

Covered Benefit	Limitations	Co-payments
reconstruction include:		
 all stages of reconstruction 		
on the affected breast;		
 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		N.
Skilled Nursing	 Requires authorization and 	None
Facilities	physician prescription	
(Includes Rehabilitation	 60 days per 12-month period limit. 	
Hospitals)	limit.	
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		
Outpatient Hospital,	 May require prior authorization 	
Comprehensive Outpatient	and physician prescription	None.
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 		
CHIP-EOC -11.28.18-Schedule D	1	4

	Covered Benefit	Limitations	Co-payments
•	Ambulatory surgical facility		
	services		
-	Drugs, medications and		
	biologicals		
-	Casts, splints, dressings		
•	Preventive health services		
•	Physical, occupational and		
	speech therapy		
•	Renal dialysis		
•	Respiratory services		
•	Radiation and chemotherapy		
•	Blood or blood products that are		
	not provided free-of-charge to		
	the patient and the		
	administration of these products		
•	Facility and related medical		
	services, such as anesthesia,		
	associated with dental care, when provided in a licensed		
	ambulatory surgical facility.		
	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. Pre-surgical or post-surgical		
-	orthodontic services for		
	medically necessary treatment		
	of craniofacial anomalies		
	requiring surgical intervention		
	and delivered as part of a		
1	proposed and clearly outlined		
	treatment plan to treat:		
	 cleft lip and/or palate; or 		
1	- severe traumatic, skeletal		
	and/or congenital craniofacial		

Covered Benefit	Limitations	Co-payments
deviations; or		
 severe facial asymmetry 		
secondary to skeletal defects,		
congenital syndromal		
conditions and/or tumor		
growth or its treatment.		
 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; 		
 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.		
Physician/Physician	May require authorization for	None
Extender Professional Services	specialty services	
Sonvices include but are not limited		
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, in-patient 		
and outpatient services		
 Laboratory, x-rays, imaging and 		
pathology services, including		
technical component and/or		
professional interpretation		

	Covered Benefit	Limitations	Co-payments
	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;		
	 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 hours following		
	an uncomplicated delivery by		
	caesarian section.		

Covered Benefit	Limitations	Co-payments
 Covered Benefit Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. 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. 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. 	Covers birthing services provided by a licensed birthing center.	None
	Limited to facility services (e.g.,	
Convision rendered by a Contificat	labor and delivery)	Nopo
Services rendered by a Certified Nurse Midwife or physician in a	Covers prenatal, birthing, and postpartum services rendered in a	None.
licensed birthing center	licensed birthing center.	
Durable Medical Equipment	 May require prior authorization 	None
	1^{-1} may require prior autionization	0

Covered Benefit	Limitationa	Co poveronto
Covered Benefit		Co-payments
(DME), Prosthetic Devices and	and physician prescription	
Disposable Medical Supplies	 \$20,000 per 12-month period 	
	limit for DME, prosthetics,	
Covered services include DME	devices and disposable medical	
(equipment that can withstand	supplies (implantable devices,	
repeated use and is primarily and	diabetic supplies and equipment	
customarily used to serve a medical	are not counted against this	
purpose, generally is not useful to a	cap).	
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 but not limited		
to:		
 Orthotic braces and orthotics 		
Dental Devices		
 Prosthetic devices such as 		
artificial eyes, limbs, braces, and		
external breast prostheses		
 Prosthetic eyeglasses and 		
contact lenses for the		
management of severe		
ophthalmologic disease		
 Other artificial aids including 		
surgical implants		
Hearing aids		
 Implantable devices are covered 		
under Inpatient and Outpatient		
services and do not count		
towards the DME 12-month		
period limit.		
 Diagnosis-specific disposable 		
medical supplies, including		
diagnosis-specific prescribed		
specialty formula and dietary		
supplements.		
Home and Community Health	 Requires prior authorization and 	None
Services	physician prescription	
	 Services are not intended to 	
Services that are provided in the	replace the CHILD'S caretaker or	
home and community, including,	to provide relief for the	
but not limited to:	caretaker.	
 Home infusion 	 Skilled nursing visits are 	

Covered Benefit	Limitations	Co-payments
 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. 	 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. 	
 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 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. 	 Requires prior authorization for non-emergency services Does not require PCP referral. 	None
Outpatient Mental Health Services	May require prior authorization.Does not require PCP referral.	None
	 A Qualified Mental Health 	

Covered Repotit	Limitations	Co poveonto
Covered Benefit		Co-payments
Mental health services, including for	Provider – Community Services	
serious mental illness, provided on	(QMHP-CS), is defined by the	
an outpatient basis, including, but	Texas Department of State	
not limited to:	Health Services (DSHS) in Title	
• The visits can be furnished in a	25 Tex. Admin. Code	
variety of community-based	§412.303(48). QMHP-CSs shall	
settings (including school and	be providers working through a	
home-based) or in a state-	DSHS-contracted Local Mental	
operated facility.	Health Authority or a separate	
 Neuropsychological and 	DSHS-contracted entity. QMHP-	
psychological testing	CSs shall be supervised by a	
 Medication management 	licensed mental health	
 Residential treatment services 	professional or physician and	
 Sub-acute outpatient services 	provide services in accordance	
(partial hospitalization or	with DSHS standards. Those	
rehabilitative day treatment)	services include individual and	
 Skills training (psycho- 	group skills training (that can be	
educational skill development	components of interventions	
 When outpatient psychiatric 	such as day treatment and in-	
services are ordered 1) by a	home services), patient and	
court of competent jurisdiction	family education, and crisis	
pursuant to the Texas Health	services.	
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.		
Inpatient and Residential	 Requires prior authorization for 	None
Substance Abuse Treatment	non-emergency services	
Services	 Does not require PCP referral. 	
Inpatient and substance abuse		
treatment services include, but are		
not limited to:		
 Inpatient and residential 		

Covered Benefit	Limitations	Co-payments
 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: a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code; or 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. 		
 Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include, but are not limited to: 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 that consists of at least 10 hours per 	 Requires prior authorization. Does not require PCP referral. 	None

Covered Benefit	Limitations	Co-payments
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		
 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.		
Rehabilitation Services	 Requires prior authorization and 	None
	physician prescription	
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 		
Hospice Care Services	 Requires authorization and 	None
-	physician prescription	
Services include, but are not limited	 Services apply to the hospice 	
to:	diagnosis.	
 Palliative care, including medical 	 Up to a maximum of 120 days 	
and support services, for those	with a 6 month life_expectancy.	
children who have six months or	 Patients electing hospice 	
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Covered Benefit	Limitations	Co-payments
 less to live, to keep patients comfortable during_the last weeks and months before death Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services. 	services may cancel this election at anytime.	
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	 Does not require authorization for post-stabilization services 	None
 Health Plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: 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, 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, and removal of cysts 	Dequires authorization	Nono
Transplants	 Requires authorization 	None
 Covered services include: Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non- 		
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Covered Benefit	Limitations	Co-payments
experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.		
 Vision Benefit Covered services include: One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period 	 The health plan may reasonably limit the cost of the frames/lenses. May require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye. 	None
Chiropractic Services Covered_services do not require physician prescription and are limited to spinal subluxation	 Requires authorization for twelve visits per 12-month period limit (regardless of number of services or modalities provided in one visit) Requires authorization for additional visits. 	None
Tobacco Cessation Program Covered up to \$100 for a 12- month period limit for a plan- approved program Value-Added Services	 May require authorization Health Plan defines plan- approved program. May be subject to formulary requirements. 	None
24-Hour Nurse Line	Members have 24-hour, 7-days-a-week access to FIRSTCALL, a bilingual medical advice infoline staffed by nurses, pharmacists, and a Medical Director on call.	None
Extra Help with Getting a Ride	A free ride service to help you get to doctor visits or health education classes.	None
Dental Services	Pregnant members 21 or older can receive up to \$500 each year for dental checkups, x- rays, routine cleaning, fillings, and extractions.	None
Discount Pharmacy / Over-the-Counter Ben	\$25 gift packet which includes a first aid kit and a \$10 Walmart gift card for health related items, for new members who complete the request form and send by return mail within 30 days of enrollment.	None

Covered Benefit	Limitations	Co-payments
Sports and school physicals	Members between the ages of 4 through18	None
	can get a free physical for sports each year.	
Help for Members with Asthma	One allergy-free pillow case is given to members who are enrolled in the Asthma Disease Management Program.	None
	Pregnant members can receive:	
Extra Help for Pregnant Women	A free convertible car seat after attending a baby shower at El Paso Health;	None
	Gift cards for completing prenatal visits and after confirmation of those visits for:	
	 \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - flu shot during pregnancy, \$25 -a timely postpartum visit within 21-56 days of delivery. A First-Steps Baby Shower including a diaper bag, a starter supply of diapers, and other items for the baby.	
Health and Wellness Services	Members age 18 or younger can receive four additional nutritional/obesity counseling services above the CHIP benefit.	None
	A \$15 gift card is offered to members ages 3- 6 and 12-19 who get a check-up when due and on time.	None
Gift Programs	The First-Steps program offers Baby Shower gifts and a convertible car seat.	
	Gift cards are offered for completion of specific activities related to your pregnancy and delivery. The gift card awards are given for the following:	
	 \$25 - Prenatal visit in the first trimester or within 42 days of enrollment, \$20 - 3rd prenatal visit, \$20 - 6th prenatal visit, \$20 - 9th prenatal visit, \$20 - a flu shot during pregnancy, \$25 - a timely postpartum visit within 21-56 days of delivery. 	

Covered Benefit	Limitations	Co-payments
Inpatient Follow -up Incentive Program	A \$10 movie gift card is offered to members 20 years and younger who complete a follow-up psychiatrist visit within 7 days of a behavioral health inpatient hospital stay. Members can receive one movie gift card per year.	None

EXCLUSIONS

- 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 patient, and other articles that are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. This exclusion is an adverse determination and is eligible for review by an Independent Review Organization (as described in D, "External Review by Independent Review Organization").
- 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.
- Dental devices solely for cosmetic purposes
- 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
- 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
- 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 (routine foot care does not include treatment for injury or complications of diabetes).
- 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 that 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).

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		Х	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		Х	Over-the-counter supply.
Alcohol, swabs (diabetic)	Х		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	Х		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	Х		A self-injection kit used by patients highly allergic to bee stings.

DME/SUPPLIES

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
Arm Sling	Х		Dispensed as part of office visit.
Attends (Diapers)	Х		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 X	
Basal Thermometer		Х	Over-the-counter supply.
Batteries – initial	Х		For covered DME items
Batteries – replacement	Х		For covered DME when replacement is necessary due to normal use.
Betadine		Х	See IV therapy supplies.
Books		Х	
Clinitest	Х		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		Х	
Contraceptive Jelly		Х	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		Х	
Dental Devices	Х		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	Х		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/ Incontinent Briefs/Chux	Х		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		Х	Contraceptives are not covered under the plan.
Diastix	Х		For monitoring diabetes.
Diet, Special		X X	
Distilled Water		Х	
Dressing Supplies/ Central Line	Х		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/ Decubitus	Х		Eligible for coverage only if receiving covered home care for wound care.
Dressing	Х		Eligible for coverage only if receiving home IV

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
Supplies/ Peripheral IV			therapy.
Therapy Dressing		Х	
Supplies/Other Dust Mask		Х	
Ear Molds	Х		Custom made, post inner or middle ear surgery
Electrodes	Х		Eligible for coverage when used with a covered DME.
Enema Supplies		Х	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	Х		Covered for patients 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

SUPPLIES	COVERE	EXCLUDE	COMMENTS/MEMBER
	D	D	CONTRACT PROVISIONS
Gloves		X	 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 <i>not</i> medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally. Exception: Central line dressings or wound
			care provided by home care agency.
Hydrogen Peroxide		Х	Over-the-counter supply.
Hygiene Items		Х	
Incontinent Pads	Х		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	Х		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	Х		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	Х		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	Х		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		Х	Over-the-counter supply.
Lancet Device	Х		Limited to one device only.
Lancets	Х		Eligible for individuals with diabetes.
Med Ejector Needles and Syringes/ Diabetic	X		See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	Х		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen Ostomy Supplies	X X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape,

SUPPLIES	COVERE D	EXCLUDE D	COMMENTS/MEMBER CONTRACT PROVISIONS
		U	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	Х		Necessary supplies (e.g., tubing, filters,
Nutrition/			connectors, etc.) are eligible for coverage when
Supplies			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;
Stump Sloovo	Х		c) for indwelling urinary catheter irrigation.
Stump Sleeve Stump Socks			
Suction	X X		
Catheters	~		
Syringes			See Needles/Syringes.
Таре			See Dressing Supplies, Ostomy Supplies, IV
			Therapy Supplies.
Tracheostomy	Х		Cannulas, Tubes, Ties, Holders, Cleaning Kits,
Supplies			etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	Х		Eligible for coverage when part of wound care
			in the home setting. Incidental charge when
			applied during office visit.
Urinary,		Х	Exception: Covered when used by incontinent
External			male where injury to the urethra prohibits use
Catheter &			of an indwelling catheter ordered by the PCP
Supplies	N/		and approved by the plan
Urinary,	X		Cover catheter, drainage bag with tubing,
Indwelling Catheter &			insertion tray, irrigation set and normal saline if needed.
Supplies			
Urinary,	Х		Cover supplies needed for intermittent or
Intermittent			straight catherization.
Urine Test Kit	Х		When determined to be medically necessary.
Urostomy			See Ostomy Supplies.
supplies			

Schedule D