CHILDREN'S HEALTH INSURANCE PROGRAM HEALTH BENEFIT PLAN
EVIDENCE OF COVERAGE
HEALTH MAINTENANCE ORGANIZATION
NON-FEDERALLY QUALIFIED PLAN

THIS EVIDENCE OF COVERAGE (CONTRACT) IS ISSUED TO YOU, WHOSE CHILD HAS ENROLLED IN EL PASO HEALTH BENEFIT PLAN THROUGH THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP). YOU AGREE TO ADHERE TO THESE PROVISIONS FOR COVERED HEALTH SERVICES BY COMPLETING THE ENROLLMENT FORM, PAYING THE APPLICABLE PREMIUM AND ACCEPTING THIS EVIDENCE OF COVERAGE. THIS DOCUMENT DESCRIBES YOUR RIGHTS AND RESPONSIBILITIES IN RELATION TO YOUR CHILD RECEIVING COVERED HEALTH SERVICES AND BENEFITS FROM EL PASO HEALTH THROUGH THE CHIP PROGRAM.

Issued by

EL PASO HEALTH
1145 Westmoreland
El Paso, Texas 79925
915-532-3778
1-877-532-3778

In association with:

Children's Health Insurance Program
P.O. Box 149276
Austin, TX 78714-9983
1-800-647-6558

CHIP-EOC

IMPORTANT NOTICE

To obtain information or make a complaint:

YOU may contact YOUR Compliance Director at 1-877-532-3778.

YOU may call EL PASO HEALTH toll-free telephone number for information or to make a complaint at

1-877-532-3778

YOU may also write to EL PASO HEALTH at
1145 Westmoreland
El Paso, Texas 79925

YOU may contact the Texas Department of Insurance to obtain information on companies, Coverages, rights or complaints at

1-800-252-3439.

YOU may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov.

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning YOUR premium or about a claim you should contact EL PASO HEALTH, first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Puede comunicarse con su Director de Quejas al1-877-532-3778

Usted puede llamar al numero de telefono gratis de EL PASO HEALTH para informacion o para someter una queja' al
1-877-532-3778

Usted tambien puede escribir a EL PASO HEALTH a
1145 Westmoreland
El Paso, Texas 79925

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439.

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771
http://www.tdi.texas.gov
ConsumerProtection@tdi.texas.gov.

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el El Paso Health primero. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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I. INTRODUCTION

A. YOUR CHILD'S Coverage under HEALTH PLAN

HEALTH PLAN provides benefits to YOUR CHILD for Covered Health Services under CHIP and determines whether particular health services are Covered Health Services, as described in **Section [XI]**, **SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES,** below. If properly enrolled, YOUR CHILD is eligible for the benefits described in **Section [XI]**. All services must be provided by participating Physicians and Providers except for Emergency Services and for out-of-network services that are authorized by HEALTH PLAN. YOU have a Contract with HEALTH PLAN regarding matters stated in this Section I.A, as more fully described in this Contract.

B. YOUR Contract with CHIP

CHIP has determined that YOUR CHILD is eligible to receive Coverage and under what circumstances the Coverage will end. CHIP also has determined YOUR CHILD'S eligibility for other benefits under the CHIP program.

II. DEFINITIONS

ADMINISTRATOR: The contractor with the state that administers enrollment functions for CHIP health plans.

Adverse Determination: A decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or are experimental or investigational.

CHILD: Any child who CHIP has determined to be eligible for Coverage and who is enrolled under this Plan.

CHIP: The Children's Health Insurance Program which provides Coverage to each CHILD in accordance with an agreement between HEALTH PLAN and the Health and Human Services Commission of the State of Texas.

Copayment: The amount that You are required to pay when your CHILD uses certain Covered Health Services within the Health Benefit Plan. Once the Copayment is made, You are not required to make further payment for these Covered Health Services.

Covered Health Services or Covered Services or Coverage: Those Medically Necessary Services that are listed in **Section [XI], SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan. Covered Services also include any additional services offered by

the HEALTH PLAN as Value Added Services (VAS) in **Section [XI] SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of this Health Benefit Plan.

Disability: A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Emergency Behavioral Health Condition: Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

1. requires immediate intervention and/or medical attention without which a CHILD would present an immediate danger to themselves or others, or
2. that renders a CHILD incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Condition: means an Emergency Medical Condition or an Emergency Behavioral Health Condition.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or

- in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

Emergency Services and **Emergency Care:** covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services.

Experimental and/or Investigational: A service or supply is Experimental and/or Investigational if WE determine that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to Phase I. II and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation

for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

WE will determine if this item 2. Is true based on:

a. Published reports in authoritative medical literature; and
b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

3. In the case of a drug, a device or other supply that is subject to FDA approval:
   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation;
   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:
      (i) included in one or more of the following medical compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services; or
      (ii) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.
4. The Physician's or Provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to that board's approval.
5. Research protocols indicate that the service or supply is Experimental or Investigational. This item 5, applies for protocols used by the CHILD'S Physician or Provider as well as for protocols used by other Physicians or Providers studying substantially the same service or supply.

Health Benefit Plan or Plan: The Coverage provided to CHILD issued by HEALTH PLAN providing Covered Health Services.

HEALTH PLAN: EL PASO HEALTH ,otherwise referred to as US, WE, or OUR.

Home Health Services: Health services provided at a CHILD'S home by health care personnel, as prescribed by the responsible Physician or other authority designated by the HEALTH PLAN.

Hospital: A licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

Illness: A physical or mental sickness or disease.

Independent Review Organization: An entity that is certified by the Commissioner of Insurance under Chapter 4202 to conduct independent review of Adverse Determinations.

Injury or Accidental Injury: Accidental trauma or damage sustained by CHILD to a body part or system that is not the result of a disease, bodily infirmity or any other cause.

Life-threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Medically Necessary Services: Health services that are:

Physical:

- reasonable and necessary to prevent Illness or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical malformation or limitations in function, threaten to cause or worsen a Disability, cause Illness or infirmity of a CHILD, or endanger life;
- provided at appropriate facilities and at the appropriate levels of care for the treatment of CHILD'S medical conditions;
- consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- consistent with diagnoses of the conditions;
- no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- are not Experimental or Investigative; and
- are not primarily for the convenience of the CHILD or health care provider.

Behavioral:

- reasonable and necessary for the diagnosis or treatment of a mental health or Chemical Dependency disorder to improve, maintain, or prevent deterioration of function resulting from the disorder;
- provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
- are not Experimental or Investigative; and

- are not primarily for the convenience of the CHILD or health care provider.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the CHILD'S physical and/or mental health or the quality of care provided.

Member: Any covered CHILD, up to age 19, who is eligible for benefits under Title XXI of the Social Security Act and who is enrolled in the Texas CHIP program.

Out-of-Area: Any location outside HEALTH PLAN'S CHIP Service Area.

Pediatrician: A Physician who is board eligible/board certified in pediatrics by the American Board of Pediatrics.

Physician: Anyone licensed to practice medicine in the State of Texas.

Primary Care Physician or Primary Care Provider (PCP): A physician or provider who has agreed with the HEALTH PLAN to provide a medical home to a CHILD and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Provider: Any institution, organization or person, other than a Physician, that is licensed to or otherwise authorized to provide a health care service in this state. The term includes, but is not limited to a hospital, doctor of chiropractic, pharmacist, registered nurse, optometrist, registered optician, pharmacy, skilled nursing facility, or home health agency.

Serious Mental Illness: The following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. schizophrenia;
2. paranoid and other psychotic disorders;
3. bipolar disorders (hypomanic, manic, depressive, and mixed);
4. major depressive disorders (single episode or recurrent);
5. schizo-affective disorders (bipolar or depressive);
6. pervasive developmental disorders;
7. obsessive-compulsive disorders; and
8. depression in childhood and adolescence.

Service Area: [Description of the HMO's geographic service area for the CHIP program]

Specialist Physician: A participating Physician, other than a Primary Care Physician, under Contract with HEALTH PLAN to provide Covered Health Services upon referral by the Primary Care Physician or Primary Care Provider.

Urgent Behavioral Health Care: A behavioral health condition that requires attention and assessment within twenty-four (24) hours but that does not place the CHILD in immediate danger to himself or herself or others and the CHILD is able to cooperate with treatment.

Urgent Care: A health condition including an Urgent Behavioral Health Care that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the CHILD's PCP or PCP designee to prevent serious deterioration of the CHILD's condition or health.

Usual and Customary Charge: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies.

Utilization Review: The system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Covered Health Services provided, being provided, or proposed to be provided to a CHILD. The term does not include elective requests for clarification of coverage.

Utilization Review Agent: An entity that is certified by the Commissioner of Insurance to conduct Utilization Review.

YOU and YOUR: The family or guardian of the CHILD.

III. WHEN DOES AN ENROLLED CHILD BECOME COVERED?

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be enrolled the 1st day of the next month following completion of the enrollment process. Children covered by private insurance within 90 days of application may be subject to a waiting period which extends for a period of 90 days after the last date on which the applicant was covered under a health benefits plan.

IV. COST-SHARING

Enrollment fees and co-pays are based on your family's income. If you are required to pay an enrollment fee for your CHILD'S CHIP coverage, the fee is due with YOUR enrollment form.

No co-payments are required for preventive services or pregnancy-related assistance.

V. TERMINATION OF CHILD'S COVERAGE

A. Disenrollment due to loss of CHIP eligibility

Disenrollment may occur if YOUR CHILD loses CHIP eligibility. YOUR CHILD may lose CHIP eligibility for the following reasons:

1. "Aging-out" when CHILD turns nineteen;
2. Failure to re-enroll by the end of the 12-month coverage period;
3. Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
4. Death of a CHILD;
5. CHILD permanently moves out of the state;
6. CHILD is enrolled in Medicaid or Medicare.
7. Failure to drop current insurance if CHILD was determined to be CHIP-eligible because health insurance cost under the current health plan totaled 10% or more of the family's net income.
8 CHILD'S parent or Authorized Representative requests (in writing) the voluntary disenrollment of a CHILD.
9. Failure to respond to a request of income verification during month six of the enrollment period (only required for certain families) or if the income information provided indicates that the family's income exceeds CHIP income limits.

B. Disenrollment by HEALTH PLAN

YOUR CHILD may be disenrolled by US, subject to approval by the Health and Human Services Commission, for the following reasons:

1. Fraud or intentional material misrepresentation made by YOU after 15 days written notice;
2. Fraud in the use of services or facilities after 15 days written notice;
3. Misconduct that is detrimental to safe Plan operations and the delivery of services;
4. CHILD no longer lives or resides in the Service Area.
5. CHILD is disruptive, unruly, threatening or uncooperative to the extent that CHILD's membership seriously impairs HEALTH PLAN's or

Provider's ability to provide services to the CHILD or to obtain new members, and the CHILD's behavior is not caused by a physical or behavioral health condition.

6. CHILD steadfastly refuses to comply with HEALTH PLAN restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HEALTH PLAN to treat the underlying medical condition).

We will not disenroll a CHILD based on a change in the CHILD'S health status, diminished mental capacity, or because of the amount of Medically Necessary Services that are used to treat the CHILD'S condition. WE will also not disenroll a CHILD because of uncooperative or disruptive behavior resulting from his or her special needs, unless this behavior seriously impairs OUR ability to furnish services to the CHILD or other enrollees.

VI. PREGNANT MEMBERS AND INFANTS

When WE receive notice from YOU, YOUR CHILD or YOUR CHILD'S Physician or Provider that a pregnancy has been diagnosed, WE will notify the HHSC Administrative Service Organization.

Depending on YOUR income and family size, the HHSC Administrative Service Organization may notify YOU and YOUR CHILD about her potential eligibility for Medicaid and of her ability to apply for Medicaid. In that situation, the Administrator will also provide appropriate resource information. A member who is potentially eligible for Medicaid must apply for Medicaid. A Member who is determined to be Medicaid-eligible will no longer be eligible for CHIP.

If YOUR CHILD is not eligible for Medicaid, the Administrator will extend YOUR CHILD'S eligibility period, if her eligibility would otherwise expire, to ensure that she continues coverage during her pregnancy and through the end of the second full month following the month of the baby's birth.

The HHSC Administrative Service Organization will enroll the newborn in the mother's CHIP plan prospectively, following standard cut-off rules.

VII. YOUR CHILD'S HEALTH COVERAGE

A. Selecting YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU shall, at time of enrollment in the HEALTH PLAN, select YOUR CHILD'S Primary Care Physician or Primary Care Provider (PCP). A female Member may select an Obstetrician/Gynecologist (OB/GYN) to provide Covered Health Services within the scope of the professional specialty practice of the OB/GYN. The selection shall be made from those Physicians and Providers listed in

HEALTH PLAN'S published list of Physicians and Providers. YOU have the option to choose as a PCP a Family Practice Physician with experience in treating children, a Pediatrician, or other age-appropriate and qualified health care Provider.

YOU shall look to the selected PCP to direct and coordinate CHILD'S care, and recommend procedures and/or treatment.

B. Changing YOUR CHILD'S Primary Care Physician or Primary Care Provider

YOU may request a change in YOUR CHILD'S Primary Care Physician or Primary Care Provider and a change in YOUR CHILD'S OB/GYN. YOUR request must be made to HEALTH PLAN at least thirty (30) days prior to the requested effective date of the change.

C. Children with Chronic, Disabling or Life-threatening Illnesses

A CHILD who has a chronic, disabling or Life-threatening Illness may be eligible to receive services above and beyond those normally provided. If YOUR CHILD is identified as having special health care needs, YOUR CHILD will be eligible for Case Management Services for Children with Special Health Care Needs (CSHCN) through the Texas Department of State Health Services.

A CHILD who has a chronic, disabling, or Life-threatening Illness may apply to HEALTH PLAN'S medical director to use a non-primary Specialist Physician as a Primary Care Physician. The Specialist Physician must agree to the arrangement and agree to coordinate all of the CHILD'S health care needs.

D. Emergency Services

When YOUR CHILD is taken to a Hospital emergency department, free-standing emergency medical facility or to a comparable emergency facility, the treating Physician/Provider will perform a medical screening examination to determine whether a medical Emergency exists and will provide the treatment and stabilization of an Emergency Condition.

If additional care is required after the patient is stabilized, the treating Physician/Provider must contact HEALTH PLAN. HEALTH PLAN must respond within one hour of receiving the call to approve or deny Coverage of the additional care requested by the treating Physician/Provider.

If HEALTH PLAN agrees to the care as proposed by the treating Physician/Provider, or if HEALTH PLAN fails to approve or deny the proposed care within one hour of receiving the call, the treating Physician/Provider may proceed with the proposed care.

YOU should notify HEALTH PLAN within twenty-four (24) hours of any out-of-network Emergency Services, or as soon as reasonably possible.

E. Out-of-Network Services

If Covered Health Services are not available to YOUR CHILD through network Physicians or Providers, HEALTH PLAN, upon the request of a network Physician or Provider, shall allow referral to an out-of-network Physician or Provider and shall fully reimburse the out-of-network Physician or Provider at the Usual and Customary Charge or at an agreed upon rate. HEALTH PLAN further must provide for a review by a specialist of the same or similar specialty as the type of Physician or Provider to whom a referral is requested before HEALTH PLAN may deny a referral.

F. Continuity of Treatment

The contract between HEALTH PLAN and a Physician or Provider must provide that reasonable advance notice be given to YOU of the impending termination from the Plan of a Physician or Provider who is currently treating YOUR CHILD. The contract must also provide that the termination of the Physician or Provider contract, except for reasons of medical competence or professional behavior, does not release HEALTH PLAN from its obligation to reimburse the Physician or Provider who is treating YOUR CHILD of special circumstance, such as a CHILD who has a Disability, acute condition, Life-threatening Illness, or is past the twenty-fourth week of pregnancy, for YOUR CHILD'S care in exchange for continuity of ongoing treatment for YOUR CHILD then receiving medically necessary treatment in accordance with the dictates of medical prudence.

Special circumstance means a condition such that the treating Physician or Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to YOUR CHILD. Special circumstance shall be identified by the treating Physician or Provider who must request that YOUR CHILD be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from YOU for any amount for which YOU would not be responsible if the Physician or Provider were still on HEALTH PLAN'S network. HEALTH PLAN shall reimburse the terminated Physician or Provider for YOUR CHILD'S ongoing treatment for ninety days from the effective date of the termination, or for nine months if YOUR CHILD has been diagnosed with a terminal Illness. For a CHILD who at the time of termination is past the twenty-fourth week of pregnancy, HEALTH PLAN shall reimburse the terminated Physician or Provider for treatment extending through delivery, immediate postpartum care, and follow-up checkup within six weeks of delivery.

G. Notice Of Claims

YOU should not have to pay any amount for Covered Health Services except for Copayments or Deductibles. If YOU receive a bill from a physician or provider that is more than your authorized Copayment or Deductible amounts, contact HEALTH PLAN.

H. Coordination of Benefits

Your CHILD'S coverage under CHIP is secondary when coordinating benefits with any other insurance coverage. This means that the coverage provided under CHIP will pay benefits for covered services that remain unpaid after any other insurance coverage has paid.

I. Subrogation

HEALTH PLAN receives all rights of recovery acquired by YOU or YOUR CHILD against any person or organization for negligence or any willful act resulting in Illness or Injury covered by HEALTH PLAN, but only to the extent of such benefits. Upon receiving such benefits from the HEALTH PLAN, YOU and YOUR CHILD are considered to have assigned such rights of recovery to HEALTH PLAN and YOU agree to give HEALTH PLAN any reasonable help required to secure the recovery.~~]~~

VIII. HOW DO I MAKE A COMPLAINT?

A. Complaint Process

"Complaint" means any dissatisfaction expressed by YOU orally or in writing to US with any aspect of OUR operation, including but not limited to, dissatisfaction with plan administration;~~,~~ procedures related to review or appeal of an Adverse Determination, the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions.

If YOU notify US orally or in writing of a Complaint, WE will, not later than the fifth business day after the date of the receipt of the Complaint, send to YOU a letter acknowledging the date WE received YOUR Complaint. If the Complaint was received orally, WE will enclose a one-page Complaint form clearly stating that the Complaint form must be returned to US for prompt resolution.

After receipt of the written Complaint or one-page Complaint form from YOU, WE will investigate and send YOU a letter with OUR resolution. The total time for acknowledging, investigating and resolving your Complaint will not exceed thirty (30) calendar days after the date WE receive YOUR Complaint.

YOUR Complaint concerning an Emergency or denial of continued stay for hospitalization will be resolved in one business day of receipt of YOUR Complaint. The investigation and resolution shall be concluded in accordance with the medical immediacy of the case.

YOU may use the appeals process to resolve a dispute regarding the resolution of YOUR Complaint.

B. Appeals to the HEALTH PLAN

1. If the Complaint is not resolved to YOUR satisfaction, YOU have the right either to appear in person before a Complaint appeal panel where YOU normally receive health care services, unless another site is agreed to by YOU, or to address a written appeal to the Complaint appeal panel. WE shall complete the appeals process not later than the thirtieth ($30^{th)}$ calendar day after the date of the receipt of the request for appeal.

2. WE shall send an acknowledgment letter to YOU not later the fifth day after the date of receipt of the request of the appeal.

3. WE shall appoint members to the Complaint appeal panel, which shall advise US on the resolution of the dispute. The Complaint appeal panel shall be composed of an equal number of OUR staff, Physicians or other Providers, and enrollees. A member of the appeal panel may not have been previously involved in the disputed decision.

4. Not later than the fifth business day before the scheduled meeting of the panel, unless YOU agree otherwise, WE shall provide to YOU or YOUR designated representative:

   a. any documentation to be presented to the panel by OUR staff;

   b. the specialization of any Physicians or Providers consulted during the investigation; and

   c. the name and affiliation of each of OUR representatives on the panel.

5. YOU, or YOUR designated representative if YOU are a minor or disabled, are entitled to:

   a. appear in person before the Complaint appeal panel;

   b. present alternative expert testimony; and

   c. request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

6. Investigation and resolution of appeals relating to ongoing emergencies or denial of continued stays for hospitalization shall be concluded in accordance with the medical immediacy of the case but in no event to exceed one business day after YOUR request for appeal.

   Due to the ongoing Emergency or continued Hospital stay, and at YOUR request, WE shall provide, in lieu of a Complaint appeal panel, a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal.

7. Notice of OUR final decision on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

C. Internal Appeal of Adverse Determination

An "Adverse Determination" is a decision that is made by US or OUR Utilization Review Agent that the health care services furnished or proposed to be furnished to a CHILD are not medically necessary or appropriate.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record disagree with the Adverse Determination, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider may appeal the Adverse Determination orally or in writing.

Within 5 business days after receiving a written appeal of the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider, a letter acknowledging the date of receipt of the appeal. The letter will also include a list of documents that YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider should send to US or to OUR Utilization Review Agent for the appeal.

If YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider orally appeal the Adverse Determination, WE or OUR Utilization Review Agent will send YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider a one-page appeal form. YOU are not required to return the completed form, but WE encourage YOU to because it will help US resolve YOUR appeal.
Appeals of Adverse Determinations involving ongoing emergencies or denials of continued stays in a Hospital will be resolved no later than 1 business day from the date all information necessary to complete the appeal is received. All other

appeals will be resolved no later than 30 calendar days after the date WE or OUR Utilization Review Agent receives the appeal.

D. External Review by Independent Review Organization

If the appeal of the Adverse Determination is denied, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record have the right to request a review of that decision by an Independent Review Organization (IRO). When WE or OUR Utilization Review Agent deny the appeal, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider will receive information on how to request an IRO review of the denial and the forms that must be completed and returned to begin the independent review process.

In circumstances involving a Life-threatening condition, YOUR CHILD is entitled to an immediate review by an IRO without having to comply with the procedures for internal appeals of Adverse Determinations. In Life-threatening situations, YOU, YOUR designated representative or YOUR CHILD'S Physician or Provider of record may contact US or OUR Utilization Review Agent by telephone to request the review by the IRO and WE or OUR utilization review agent will provide the required information.

When the IRO completes its review and issues its decision, WE will abide by the IRO's decision. WE will pay for the IRO review.

The appeal procedures described above do not prohibit YOU from pursuing other appropriate remedies, including injunctive relief, declaratory judgment, or other relief available under law, if YOU believe that the requirement of completing the appeal and review process places YOUR CHILD'S health in serious jeopardy.

E. Filing Complaints with the Texas Department of Insurance

Any person, including persons who have attempted to resolve complaints through OUR complaint system process and who are dissatisfied with the resolution, may report an alleged violation to the Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. Complaints to the Texas Department of Insurance may also be filed electronically at www.tdi.texas.gov.

The Commissioner of Insurance shall investigate a complaint against US to determine compliance within sixty (60) days after the Texas Department of Insurance’s receipt of the Complaint and all information necessary for the Department to determine compliance. The Commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

1. additional information is needed;

2. an on-site review is necessary;
3. WE, the Physician or Provider, or YOU do not provide all documentation necessary to complete the investigation; or
4. other circumstances beyond the control of the Department occur.

F. Retaliation Prohibited

1. WE will not take any retaliatory action, including refusal to renew coverage, against a CHILD because the CHILD or person acting on behalf of the CHILD has filed a Complaint against US or appealed a decision made by US.

2. WE shall not engage in any retaliatory action, including terminating or refusal to renew a contract, against a Physician or Provider, because the Physician or Provider has, on behalf of a CHILD, reasonably filed a Complaint against US or has appealed a decision made by US.

IX. GENERAL PROVISIONS

A. Entire Agreement, Amendments

This Contract, and any attachments or amendments are the Entire Agreement between YOU and HEALTH PLAN. To be valid, any changes to this Contract must be approved by an officer of HEALTH PLAN and attached to this Contract.

B. Release and Confidentiality of Medical Records

HEALTH PLAN agrees to maintain and preserve the confidentiality of any and all medical records of YOUR CHILD or YOUR family. However, by enrolling in HEALTH PLAN, YOU authorize the release of information, as permitted by law, and access to any and all of medical records of YOUR CHILD for purposes reasonably related to the provision of services under this Contract, to HEALTH PLAN, its agents and employees, YOUR CHILD'S Primary Care Physician or Primary Care Provider, participating Providers, outside Providers of Utilization Review Committee, CHIP and appropriate governmental agencies. HEALTH PLAN's privacy protections are described in more detail in its Notice of Privacy Practices. The Notice of Privacy Practices is available at [list website or address] or you may request a copy by calling [ ].

C. Clerical Error

Clerical error or delays in keeping records for YOUR and YOUR CHILD'S Contract with CHIP:

1. Will not deny Coverage that otherwise would have been granted; and

2. Will not continue Coverage that otherwise would have terminated.

If any important facts given to the CHIP about YOUR CHILD are not accurate and they affect Coverage:

1. the true facts will be used by CHIP to decide whether Coverage is in force; and

2. any necessary adjustments and/or recoupments will be made.

D. Notice

Benefits under Workers' Compensation are not affected.

E. Validity

The unenforceability or invalidity of any provision of this Evidence of Coverage shall not affect the enforceability or validity of the rest of this Contract.

F. Conformity with State Law

Any provision of this Contract that is not in conformity with the Texas HMO Act, and state or federal laws or regulations governing CHIP, or other applicable laws or regulations shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act, state and federal laws or regulations governing CHIP, and other applicable laws or regulations.

[CHIP EOC BENEFIT SCHEDULE A]
[CHIP EOC BENEFIT SCHEDULE B]
[CHIP EOC BENEFIT SCHEDULE C]
[CHIP EOC BENEFIT SCHEDULE D]
[CHIP EOC BENEFIT SCHEDULE E]

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 Inpatient Rehabilitation Hospital Services 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 medically necessary ▪ 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	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ May require 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 caesarian section.	$15 inpatient co-payment per admission.

Covered Benefit	Limitations	Co-payments*
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 surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and		

Covered Benefit	Limitations	Co-payments*
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 Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	▪ Requires authorization and physician prescription. ▪ 60 days per 12-month period limit.	None
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services	▪ Requires prior authorization and physician prescription.	$0 co-payment for generic drugs. $3 co-payment for brand drugs.

Covered Benefit	Limitations	Co-payments*
▪ 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: - 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		

Covered Benefit	Limitations	Co-payments*
▪ 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 Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, 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:	May require authorization for specialty services.	$3 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
- 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. ▪ 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		

Covered Benefit	Limitations	Co-payments*
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 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	▪ May require prior authorization and physician prescription.	None

Covered Benefit	Limitations	Co-payments*
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.	▪ $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 cap).	
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that	▪ Requires prior authorization and physician prescription. ▪ 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.	None

Covered Benefit	Limitations	Co-payments*
skilled visits have been approved. ▪ Speech, physical and occupational therapies.	▪ 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.	▪ Requires prior authorization for non-emergency services. ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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.	$15 inpatient co-payment.
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility	▪ Requires prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric services	$3 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
▪ Neuropsychological and psychological testing. ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development)	are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §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	

Covered Benefit	Limitations	Co-payments*
	day treatment and in-home services), patient and family education, and crisis services.	
Inpatient Substance Abuse Treatment Services Inpatient 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.	▪ Requires prior authorization for non-emergency services. ▪ Does not require PCP referral.	$15 inpatient co-payment.
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services include, but are not limited to, the following: ▪ Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. ▪ Intensive outpatient services ▪ Partial hospitalization ▪ Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training 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.	▪ Requires prior authorization. ▪ Does not require PCP referral.	$3 co-payment for office visit.
Rehabilitation Services Habilitation (the process of supplying a child with the means	▪ Requires prior authorization and physician prescription.	None

Covered Benefit	Limitations	Co-payments*
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 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 services 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	▪ Does not require authorization for post-stabilization services.	$3 co-payment for non-emergency ER.

Covered Benefit	Limitations	Co-payments*
▪ Emergency ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts		
Transplants 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.	▪ Requires authorization.	None
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. ▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	$3 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.	$3 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

Schedule A

Covered Benefit	Limitations	Co-payments*
Value-added Services **Transportation** Help getting a ride to doctor visits o health classes for Members who ne ride **Extra dental services above the CHIP Benefit** (initial exam, x-rays, and cleaning) pregnant Members . **Extra Vision Benefits** 25% off lenses and frames above the CHIP benefit 20% off certain contact lenses ab the CHIP benefit **Discount Pharmacy/Over-the Counter Services** Welcome Packet: A $15 value of over- the-counter items if the request form is completed and mailed back within 30 days of enrollment **Health and Wellness Benefits** 4 extra food counseling services, ab the CHIP benefit for Members age 1 and under **Gift Programs** Gift card for health items for pregnant Members completing a pregnancy visit within 30 days of enrollment and going to a pregnancy class **Recreation Programs** Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members		None

* 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
- 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 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).

DME/SUPPLIES

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

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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for 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 *not* medically necessary, are not covered, regardless of whether these regular food products are taken

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplie	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
s			the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

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 Inpatient Rehabilitation Hospital Services 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 medically necessary ▪ 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	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ 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 caesarian section.	$35 inpatient co-payment per admission.

Covered Benefit	Limitations	Co-payments*
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 surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of		

Covered Benefit	Limitations	Co-payments*
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 Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	▪ Requires authorization and physician prescription ▪ 60 days per 12-month period limit.	None
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility	▪ May require prior authorization and physician prescription	$0 co-payment for generic drugs. $5 co-payment for brand drugs.

Covered Benefit	Limitations	Co-payments*
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: - cleft lip and/or palate; or - 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 Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services,	May require authorization for specialty services	$5 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
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		

Covered Benefit	Limitations	Co-payments*
newborn(s) for a minimum of 48 hours following 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.		

Covered Benefit	Limitations	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 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	▪ 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 cap).	None

Covered Benefit	Limitations	Co-payments*
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 Services Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies.	▪ Requires prior authorization and physician prescription ▪ 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	None
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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to	$35 inpatient co-payment.

Covered Benefit	Limitations	Co-payments*
	court ordered commitments to psychiatric facilities, 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.	
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ 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	▪ Requires prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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. ▪ A Qualified Mental	$5 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
	Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §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.	
Inpatient Substance Abuse Treatment 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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. .	$35 inpatient co-payment.
Outpatient Substance Abuse	▪ Requires prior	$5 co-payment for

Covered Benefit	Limitations	Co-payments*
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 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.	authorization. ▪ Does not require PCP referral.	office visit.
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	▪ Requires authorization and physician prescription ▪ Services apply to the hospice diagnosis.	None

Covered Benefit	Limitations	Co-payments*
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.	▪ Up to a maximum of 120 days with a 6 month life expectancy. ▪ Patients electing hospice may cancel this election at anytime.	
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 ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	▪ Does not require authorization for post-stabilization services	$5 co-payment for non-emergency ER.
Transplants Covered services include: ▪ Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and	▪ Requires authorization	None

Covered Benefit	Limitations	Co-payments*
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. ▪ Requires 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- mon 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 **Transportation** Help getting a ride to doctor visits health classes for Members who r a ride **Extra dental services above the CHIP Benefit** (initial exam, x-rays, and cleaning		None

Covered Benefit	Limitations	Co-payments*
pregnant Members . **Extra Vision Benefits** 25% off lenses and frames above the CHIP benefit 20% off certain contact lenses a the CHIP benefit **Discount Pharmacy/Over-the Counter Services** Welcome Packet: A $15 value of over- the-counter items if the request form is completed and mailed back within 30 days of enrollment **Health and Wellness Benefits** 4 extra food counseling services, above the CHIP benefit for Membe age 18 and under **Gift Programs** Gift card for health items for pregnant Members completing a pregnancy visit within 30 days of enrollment and going to a pregnancy class **Recreation Programs** Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members		

* 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
- 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).

DME/SUPPLIES

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

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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for 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 *not*

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.

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

X. ENROLLMENT PERIOD FAMILY COPAYMENT MAXIMUM

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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 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 medically necessary ▪ ICU and services ▪ Patient meals and special	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ Requires authorization for in-network or out-of-network facility and Physician services for a mother and her newborn(s) after 48	$75 inpatient co-payment per admission.

Covered Benefit	Limitations	Co-payments*
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, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to:	hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.	

Covered Benefit	Limitations	Co-payments*
- 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		
Skilled Nursing	▪ Requires	None

Covered Benefit	Limitations	Co-payments*
Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	authorization and physician prescription ▪ 60 days per 12-month period limit.	
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility services ▪ Drugs, medications and biologicals ▪ Casts, splints, dressings ▪ Preventive health services ▪ Physical, occupational and speech therapy ▪ Renal dialysis ▪ 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	▪ Requires prior authorization and physician prescription	$10 co-payment for generic drugs. $35 co-payment for brand drugs.

Covered Benefit	Limitations	Co-payments*
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 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;		

Covered Benefit	Limitations	Co-payments*
- 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 Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, 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 surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA	May require authorization for specialty services	$20 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
- 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. ▪ 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		

Covered Benefit	Limitations	Co-payments*
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 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	▪ May require prior authorization and physician prescription	None

Covered Benefit	Limitations	Co-payments*
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.	▪ $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 cap).	
Home and Community Health Services Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health	▪ Requires prior authorization and physician prescription ▪ Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker.	None

Covered Benefit	Limitations	Co-payments*
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.	▪ 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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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.	$75 inpatient co-payment.
Outpatient Mental Health Services Mental health services,	▪ Requires prior authorization. ▪ Does not require	$20 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development	PCP referral. ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §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	

Covered Benefit	Limitations	Co-payments*
	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.	
Inpatient Substance Abuse Treatment Services Inpatient 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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral.	$75 inpatient co-payment.
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	▪ Requires prior authorization. ▪ Does not require PCP referral.	$20 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
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.		
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 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 services 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	▪ Does not require authorization for post-stabilization services	$75 co-payment for non-emergency ER.

Covered Benefit	Limitations	Co-payments*
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 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.	▪ Requires authorization	None
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. ▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	$20 co-payment for office visit.
Chiropractic Services	▪ Requires	$20 co-payment

Covered Benefit	Limitations	Co-payments*
Covered services do not require physician prescription and are limited to spinal subluxation	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.	for office visit.
Tobacco Cessation Program Covered up to $100 for a 12- mon 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 **Transportation** Help getting a ride to doctor visits health classes for Members who r a ride **Extra dental services above the CHIP Benefit** (initial exam, x-rays, and cleaning pregnant Members . **Extra Vision Benefits** 25% off lenses and frames above the CHIP benefit 20% off certain contact lenses a the CHIP benefit **Discount Pharmacy/Over-the Counter Services** Welcome Packet: A $15 value of over- the-counter items if the request form is completed and mailed back within 30 days of enrollment **Health and Wellness Benefits** 4 extra food counseling services, above the CHIP benefit for Membe age 18 and under		None

Schedule C

Covered Benefit	Limitations	Co-payments*
Gift Programs Gift card for health items for pregnant Members completing a pregnancy visit within 30 days of enrollment and going to a pregnancy class **Recreation Programs** Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members		

*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
- 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).

DME/SUPPLIES

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

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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for 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 *not* medically necessary, are not covered, regardless of whether these regular food products are taken

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplie	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
s			the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

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 Inpatient Rehabilitation Hospital Services 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 medically necessary ▪ 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	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ 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 caesarian section.	$125 inpatient co-payment per admission.

Covered Benefit	Limitations	Co-payments*
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 surgical implants ▪ Inpatient services for a mastectomy and breast reconstruction include: - all stages of		

Covered Benefit	Limitations	Co-payments*
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 Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of appliances and equipment furnished by the facility	▪ Requires authorization and physician prescription ▪ 60 days per 12-month period limit.	None
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: ▪ X-ray, imaging, and radiological tests (technical component) ▪ Laboratory and pathology services (technical component) ▪ Machine diagnostic tests ▪ Ambulatory surgical facility	▪ Requires prior authorization and physician prescription	$10 co-payment for generic drugs. $35 co-payment for brand drugs.

Covered Benefit	Limitations	Co-payments*
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: - cleft lip and/or palate; or - 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 Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, in-patient and outpatient services ▪ Laboratory, x-rays, imaging and pathology services,	May require authorization for specialty services	$25 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
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		

Covered Benefit	Limitations	Co-payments*
newborn(s) for a minimum of 48 hours following 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.		

Covered Benefit	Limitations	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 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	▪ 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 cap).	None

Covered Benefit	Limitations	Co-payments*
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 Services Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies.	▪ Requires prior authorization and physician prescription ▪ 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.	None
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	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to	$125 inpatient co-payment.

Covered Benefit	Limitations	Co-payments*
	psychiatric facilities, 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.	
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development)	▪ Requires prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services	$25 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
	(DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §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.	
Inpatient Substance Abuse Treatment Services Inpatient 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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral.	$125 inpatient co-payment.
Outpatient Substance Abuse Treatment Services Out patient substance abuse treatment services include, but are not limited to: ▪ Prevention and intervention	▪ Requires prior authorization. ▪ Does not require PCP referral.	$25 co-payment for office visit.

Covered Benefit	Limitations	Co-payments*
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 one to two hours per week providing structured group and individual therapy, educational services, and life skills training.		
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 death ▪ Treatment 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.	None

Covered Benefit	Limitations	Co-payments*
including treatment related to the terminal illness, are unaffected by electing hospice care services.	▪ Patients electing hospice services may cancel this election at anytime.	
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 ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	▪ Does not require authorization for post-stabilization services	$75 co-payment for non-emergency ER.
Transplants 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.	▪ Requires authorization	None

Schedule D

Covered Benefit	Limitations	Co-payments*
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. ▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	$25 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.	$25 co-payment for office visit.
Tobacco Cessation Program Covered up to $100 for a 12- mon 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 **Transportation** Help getting a ride to doctor visits health classes for Members who r a ride **Extra dental services above the CHIP Benefit** (initial exam, x-rays, and cleanin pregnant Members . **Extra Vision Benefits** 25% off lenses and frames above the CHIP benefit		None

Covered Benefit	Limitations	Co-payments*
20% off certain contact lenses a the CHIP benefit **Discount Pharmacy/Over-the Counter Services** Welcome Packet: A $15 value of over- the-counter items if the request form is completed and mailed back within 30 days of enrollment **Health and Wellness Benefits** 4 extra food counseling services, above the CHIP benefit for Membe age 18 and under **Gift Programs** Gift card for health items for pregnant Members completing a pregnancy visit within 30 days of enrollment and going to a pregnancy class **Recreation Programs** Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members		

*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
- 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)

DME/SUPPLIES

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

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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for 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 *not* medically necessary, are not covered, regardless of whether these regular food products are taken

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplie	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
s			the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

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	Co-payments
Inpatient General Acute and Inpatient Rehabilitation Hospital Services 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 medically necessary ▪ 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, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable	▪ Requires authorization for non-Emergency Care and care following stabilization of an Emergency Condition. ▪ 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 caesarian section.	None

Covered Benefit	Limitations	Co-payments
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		
Skilled Nursing Facilities (Includes Rehabilitation Hospitals) Services include, but are not limited to, the following: ▪ Semi-private room and board ▪ Regular nursing services ▪ Rehabilitation services ▪ Medical supplies and use of	▪ Requires authorization and physician prescription ▪ 60 days per 12-month period limit.	None

Covered Benefit	Limitations	Co-payments
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 (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	▪ Requires prior authorization and physician prescription	None.

Covered Benefit	Limitations	Co-payments
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 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 Extender Professional Services Services include, but are not limited to the following: ▪ American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations) ▪ Physician office visits, 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:	May require authorization for specialty services	None

Covered Benefit	Limitations	Co-payments
- 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. ▪ 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.		

Covered Benefit	Limitations	Co-payments
▪ 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 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 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	▪ 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 cap).	None

Covered Benefit	Limitations	Co-payments
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 Services Services that are provided in the home and community, including, but not limited to: ▪ Home infusion ▪ Respiratory therapy ▪ Visits for private duty nursing (R.N., L.V.N.) ▪ Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). ▪ Home health aide when included as part of a plan of care during a period that skilled visits have been approved. ▪ Speech, physical and occupational therapies.	▪ Requires prior authorization and physician prescription ▪ 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.	None
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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. ▪ When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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	None

Covered Benefit	Limitations	Co-payments
	determination.	
Outpatient Mental Health Services Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to : . ▪ The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. ▪ Neuropsychological and psychological testing. ▪ Medication management ▪ Rehabilitative day treatments ▪ Residential treatment services ▪ Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) ▪ Skills training (psycho-educational skill development)	▪ Requires prior authorization. ▪ Does not require PCP referral. ▪ When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, 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. ▪ A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §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	None

Covered Benefit	Limitations	Co-payments
	education, and crisis services.	
Inpatient Substance Abuse Treatment Services Inpatient 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.	▪ Requires prior authorization for non-emergency services ▪ Does not require PCP referral. ▪	None
Outpatient Substance Abuse Treatment Services Outpatient substance abuse treatment services nclude, 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 one to two hours per week providing structured group and individual therapy, educational services, and life skills training.	▪ Requires prior authorization. ▪ Does not require PCP referral.	None
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:	▪ Requires authorization and physician prescription	None

Covered Benefit	Limitations	Co-payments
▪ 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.	▪ 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.	
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 ground, air and water transportation ▪ Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	▪ Does not require authorization for post-stabilization services	None
Transplants 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.	▪ Requires authorization	None
Vision Benefit Covered services include: ▪ One examination of the eyes to	▪ The health plan may reasonably limit the cost of the frames/lenses.	None

Covered Benefit	Limitations	Co-payments
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	▪ Requires authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	
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) ▪ Requiresauthorization for additional visits.	None
Tobacco Cessation Program Covered up to $100 for a 12- month period for a plan- approved program	▪ May require authorization ▪ Health Plan defines plan-approved program. ▪ May be subject to formulary requirements.	None
Value-added Services **Transportation** Help getting a ride to doctor visits or health classes for Members who need a ride **Extra dental services above the CHIP Benefit** (initial exam, x-rays, and cleaning) for preg Members . **Extra Vision Benefits** 25% off lenses and frames above the CHIP benefit 20% off certain contact lenses above the CHIP benefit **Discount Pharmacy/Over-the Counter Services** Welcome Packet: A $15 value of over-the-counter items if the request form is completed and mailed back within 30 days of enrollment **Health and Wellness Benefits** 4 extra food counseling services, above the		None

Schedule E

Covered Benefit	Limitations	Co-payments
CHIP benefit for Members age 18 and unde **Gift Programs** Gift card for health items for pregnant Members completing a pregnancy visit within 30 days of enrollment and going to a pregnancy class **Recreation Programs** Up to $25 for any sport registration activity fee, once every 12 months for CHIP Members		

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
- 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).

DME/SUPPLIES

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

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

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for 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 *not* medically necessary, are not covered, regardless of whether these regular food products are taken

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
			orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplie	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
s			the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.